

1
FOR STATE
HEALTH DEPT.
M
X
1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10496

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G297 10/5/61 iwk

10490

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland b. COUNTY Prince George		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6212 - 41st. Place			e. STREET ADDRESS 6212 41 st Place		
3. NAME OF DECEASED (Type or print) Robert William Albright			4. DATE OF DEATH Month September Day 27 Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 30, 1910	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months 5 Days 15 Hours 50 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Airplane		11. BIRTHPLACE (State or foreign country) Illinois	
13. FATHER'S NAME William Ellsworth Albright		12. CITIZEN OF WHAT COUNTRY? U.S. A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1928-1932		16. SOCIAL SECURITY NO. 543-07-4873		17. INFORMANT Helen Albright Winfree, same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary artery disease (e), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		M.D. JAMES I. BOYD, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Sept. 27, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF SEPT 30, 1961		22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY	
22d. LOCATION (City, town, or country)		(State)		BLADENSBURG, MARYLAND	
23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.		ADDRESS		24a. REC'D BY REGISTRAR OCT 2 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines		DATE			

2. ELVAT 7A/E

1947-1948 - 2128

2580

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10497

10491

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b 13 hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 44 Cottage City d. STREET ADDRESS 3707 43rd Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Belle Middle Vista Last Allison		4. DATE OF DEATH Month Sept. Day 12 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 24, 1883
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 7 Days 12	11. IF UNDER 24 HRS. Hours 12 Min. 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) Glen Rock, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas R. Herbert		14. MOTHER'S MAIDEN NAME Elvirah Kerchner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 331X	
17. INFORMANT Daughter - M. Jones, 3707-43rd Ave		Address Cottage City Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (Stroke) cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension (c) arteriosclerosis (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-11 , 1961, to 9-12 , 1961, that (I) (we) last saw the deceased alive on 9-12 , 1961, and that death occurred at 11 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Louis M. Jimal		22b. DATE SIGNED 9-12-61	
22c. PHYSICIAN'S NAME (Type) Louis M. Jimal		22d. ADDRESS Cottage City, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-14-61	23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	23d. LOCATION (City, town, or county) (State) Glen Rock, Penna.
24. FUNERAL DIRECTOR'S SIGNATURE Isidor Katerstein, New Freedom, Pa.		25a. REC'D BY REGISTRAR SEP 18 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

MEDICAL CERTIFICATION

1. PLACE OF DEATH

10193

10193

1

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18, Form Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>10498</div> <div>10493</div> </div> </div> <div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>10498</div> <div>10493</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Richmond c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Richmond d. STREET ADDRESS 6509 Hull Street Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Walter Edward Armes 4. DATE OF DEATH September 7, 1961						5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH September 17/12 48st 9. AGE (In years last birthday) 13 IF UNDER 1 YEAR IF UNDER 24 HRS. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heavy Equipment 10b. KIND OF BUSINESS OR INDUSTRY Construction 11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? U. S.A.					
13. FATHER'S NAME James John Armes 14. MOTHER'S MAIDEN NAME Lou Frost						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. UNKNOWN 17. INFORMANT 2235 Arton St. Pahlina Armes, Oxon Run Hills, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Coronary heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 425.1 DUE TO Coronary heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE James I. Boyd M.D. DATE SIGNED Sept. 7, 1961 EXAMINER'S NAME (Type) James I. Boyd Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9-10-1961 22c. NAME OF CEMETERY OR CREMATORY TUSKIA CHURCH CEMETERY 22d. LOCATION (City, town, or country) (State) LUNENBURG CO, VIRGINIA											
23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md 24a. REC'D BY REGISTRAR SEP 11 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Hines											

MEDICAL CERTIFICATION



02201

Prince George's

* * *

Appendix 1

What is

02-2010

Enslin, James, Oxon Run Mills, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
TSM 9/59

1
10500
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10494

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3808 Powhatan Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle W Last Ault		4. DATE OF DEATH Month September Day 19 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 27, 1904
9. AGE (In years last birthday) 56		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Washington D C		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Ray C Ault		14. MOTHER'S MAIDEN NAME Mary E King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216 09 3131	
17. INFORMANT Nellie Mae Ault		Address Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastasis to Liver		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-1-1958 to 9-19-1963 , that (I) (we) last saw the deceased alive on 9-19-1961 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE A Deitz		22b. DATE Sept 19, 1961	
22c. PHYSICIAN'S NAME (Type) A Deitz		22d. ADDRESS Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/22/61	
23c. NAME OF CEMETERY OR CREMATORIUM George Washington		23d. LOCATION (City, town, or county) (State) Hyattsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DATE SEP 25 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

10404

10200

M

21

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10501 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10495

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. G.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chapel Hill</u>				c. LENGTH OF STAY IN b. <u>4 1/2 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8617 Washington Ave</u>				d. STREET ADDRESS <u>18617 Washington Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Robert Gover Baden</u>				4. DATE OF DEATH <u>Sept 22 1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 27, 1884</u>	
9. AGE (In years last birthday) <u>77</u>		IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u>		IF UNDER 24 HRS. Hours <u>77</u> Min. <u>77</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>chief clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Southern Ry.</u>			
11. BIRTH PLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>James Early Baden</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Early</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>1M-50-6215</u>			
17. INFORMANT <u>James Early Baden</u>				Address <u>Box 284 Rt #1</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> 442X DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county) <u>W. W. Chambers Co. 517 11th St. S.E.</u>				DATE SIGNED <u>9/22/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-26-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST PAUL'S</u>		22d. LOCATION (City, town, or country) (State) <u>BADEN Maryland</u>	
23. FUNERAL DIRECTOR <u>W. W. Chambers Co.</u>				24a. REC'D BY REGISTRAR <u>SEP 26 '61</u>			
ADDRESS <u>517 11th St. S.E.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



...and the ...

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10502

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10496

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Washington , b. COUNTY Prince George's Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Manor, 4922 LaSalle Road.		e. STREET ADDRESS 1730 Lanier Place	
3. NAME OF DECEASED (Type or print) Vincent William Bailey		4. DATE OF DEATH Month September , Day 24 , Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 16/71 90^{rs}
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Clothing	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vincent Bailey		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 4000 Mass. Ave N.W.	
17. INFORMATION Vincent L. Bailey, Washington D.C.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 9037 DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of the right Hip (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fell on the floor while going to the bath room	
20c. TIME OF INJURY Month, Day, Year 5:00xx 8/21/61	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) AT nursing Home	20f. (City or town) (County) (State) Avondale P.G. Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED Sept. 25, 1961	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/27/61	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or country) (State) Washington D.C.	
23. FUNERAL DIRECTOR F. Gasch's Sons		24a. REC'D BY REGISTRAR SEP 29 '61	
ADDRESS Hyattsville, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Krueger	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10138

(M)

Princess George's
Hastingsville
Hastingsville

4000 West Ave N.W.
Washington D.C.
4000 West Ave N.W.

U.S.A.
New York
U.S.A.

September 18/VI 30
October 18/VI 30
October 18/VI 30

Unknown
Unknown
Unknown

Pneumonia
Pneumonia
Pneumonia

Pressure of the right eye
Pressure of the right eye
Pressure of the right eye

Pressure of the right eye
Pressure of the right eye
Pressure of the right eye

Pressure of the right eye
Pressure of the right eye
Pressure of the right eye

Pressure of the right eye
Pressure of the right eye
Pressure of the right eye

Pressure of the right eye
Pressure of the right eye
Pressure of the right eye

Pressure of the right eye
Pressure of the right eye
Pressure of the right eye

Pressure of the right eye
Pressure of the right eye
Pressure of the right eye

Pressure of the right eye
Pressure of the right eye
Pressure of the right eye

Pressure of the right eye
Pressure of the right eye
Pressure of the right eye

Pressure of the right eye
Pressure of the right eye
Pressure of the right eye

Pressure of the right eye
Pressure of the right eye
Pressure of the right eye

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10503

Item 23 Film G295 9/19/61 iwk

10497

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 3 HRS 53 MIN d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF HOSP, ANDREWS AFB, MD			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY DISTRICT OF COLUMBIA c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 11 RUDDER GREEN SW e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last KAREN ANN Barna			4. DATE OF DEATH Month Day Year Sept 6 1961		
5. SEX FEMALE	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 Sept 61	9. AGE (In years last birthday) 623	10. IF UNDER 1 YEAR Months Days 3 53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES
13. FATHER'S NAME JOSEPH GEORGE BARNA			14. MOTHER'S MAIDEN NAME JACQUELINE LOUISE MILLER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address FATHER SAME AS ITEM #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia + Atelectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) Prematurity (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 3' 53"
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (his hospital) attended the deceased from 6 Sept 1961 to 6 Sept 1961 that (I) (we) last saw the deceased alive on 6 September 1961 , and that death occurred at 1030 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Hestley D. Stapp Capt USAF (maj)			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6 September 61
22c. PHYSICIAN'S NAME (Type) Stapp, Hestley D. CAPT USAF MC			22d. ADDRESS USAF Hosp, Andrews AFB, MD		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY D.C. Morgue	23d. LOCATION (City, town or county) (State) 19th. & E St. S.E. Washington, D.C.		
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	25a. REC'D BY REGISTRAR DATE SEP 13 '61	25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

TO HO: AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2050235XV0

10193

10003

M

C

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10504

10498

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i> c. LENGTH OF STAY IN 1b <i>20 DAYS</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince George's General Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Prince George's</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LANDOVER</i> d. STREET ADDRESS <i>Box 59</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Minnie E. BARNACKO</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>15</i> Year <i>1961</i>			
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>Sept 13, 1902</i>		9. AGE (In years last birthday) <i>58</i> yrs.		IF UNDER 1 YEAR Months <i></i> Days <i></i> IF UNDER 24 HRS. Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		13. FATHER'S NAME <i>Eugene Windsor</i>		14. MOTHER'S MAIDEN NAME <i>Fannie E. Ferguson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT Address <i>Helen Alvey - Same as #2</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i> <i>540.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pleuritis</i> DUE TO (c) <i>Sub Atrial Septal Defect</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <i>6 hours</i> <i>4 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i></i> p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <i>2-1-1960</i> to <i>9-15-1961</i> , that (I) (we) last saw the deceased alive on <i>9-15-1961</i> , and that death occurred at <i>7:20 PM</i> , from the causes and on the date stated above.					
22a. SIGNATURE <i>Dr. Saul Schwartzbach</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>DR. SWARTZBACH</i>		22d. ADDRESS <i>1726 Eye St., N.W. Washington 6, D.C.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sept 19, 1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>XXXXXXX Arlington National</i>	
23d. LOCATION (City, town or county) <i>Arlington Virginia</i>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 21 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>					

VR A15 (4)
15M 9/60

10198

10504

M

Sept 12, 1901 Wilmington, Delaware

Wm. H. Dyer, Esq.

TO HOLOGRAPHIC OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10505

10499

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PG</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>67 Green Belt</u> d. STREET ADDRESS <u>1 17 A Ridge Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>MARY T. BARNES</u>			4. DATE OF DEATH <u>Sept. 16, 1961</u>		
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>Canada</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John Brannon</u>			14. MOTHER'S MAIDEN NAME <u>Mary Omsby</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year of service)			16. SOCIAL SECURITY NO. <u>None</u>		
17. INFORMANT <u>Thomas J. Barnes</u> Address <u>same as #2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>570.2</u> DUE TO <u>Toxemia & Shock</u> Conditions, if any, which gave rise to immediate cause (b) <u>Sanguine Purcell ulcer?</u> (c) <u>Sepsis mesent. art. thromb.</u> DUE TO <u>38 hrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>3-3 hour</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3-3 hour</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 15, 1961</u> to <u>Sept 16, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 16, 1961</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>William C. Weintraub</u> M.D.			22b. DATE SIGNED <u>9-16-61</u>		
22c. PHYSICIAN'S NAME (Type) <u>William C. Weintraub</u>			22d. ADDRESS <u>9E Parkway, Greenbelt, Md</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/19/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery Wash. D. C.</u>	
23d. LOCATION (City, town, or county) (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u> ADDRESS <u>5801 Cleveland Ave</u>			25a. REC'D BY REGISTRAR <u>SEP 19 61</u>		
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>					

02501

40291

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale	
c. LENGTH OF STAY IN 1b 3 Days		d. STREET ADDRESS 5707 Longfellow Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James First BERNARD Middle Belt Last		4. DATE OF DEATH Sept. 30 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 7, 1893
9. AGE (in years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 6 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ARTIFICIAL LIMB, MAKER		10b. KIND OF BUSINESS OR INDUSTRY Artificial Limb Mfr.	
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Belt		14. MOTHER'S MAIDEN NAME Sallie Thompson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Mrs. Bernadine M. Parnell		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHOGENIC CARCINOMA DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 2-3 MONTHS UNKNOWN		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/23 , 19 61 , to Sept. 30 , 19 61 , that (I) (we) last saw the deceased alive on 9/30 , 19 61 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. James Duke M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Dr. James Duke, M.D.		22d. ADDRESS 6607 Riverdale Road, Riverdale, Md.	
22b. DATE SIGNED 10/1/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 4, 1961	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem		23d. LOCATION (City, town or county) (State) Bladensburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Riverdale, Md		25a. REC'D BY REGISTRAR DATE OCT 4 '61	
		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

1

10300

10300

10300

10300

10300

10300

10300

10300

10300

10300

10300

10300

10300

10300

10300

10300

10300

10300

10300

10300

10300

10300

10300

10300

10300

10300

10300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10507					10501				
1. PLACE OF DEATH a. COUNTY <u>Prince Geo County</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale, Md.</u> c. LENGTH OF STAY IN 1b <u>44 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eugene Leland Memorial</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Geo.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>University Pk.</u> d. STREET ADDRESS <u>6411 Colesville Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Bell</u> Last <u>Bierly</u>			4. DATE OF DEATH Month <u>9</u> Day <u>19</u> Year <u>19 61</u>						
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-14-83</u>		9. AGE (In years last birthday) <u>78</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proof Reader</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Govt Printing Office</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Willis R. Bierly</u>					14. MOTHER'S MAIDEN NAME <u>Sarah Bosard</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>214-34-6886</u>		17. INFORMANT <u>Record Office</u> Address <u>4408 Queensbury Rd.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (b) <u>CARDIOVASCULAR ARTERIOSCLEROTIC</u> (a), stating the underlying cause last. DUE TO <u>HEART DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARCINOMA OF Right colon c obstruction</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN</u> <u>5 yrs</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Arthur L. Trause</u> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>9/22/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		23d. LOCATION (City, town or county) (State) <u>Hyattsville, Md.</u>		
24 FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch's Sons</u>					ADDRESS <u>Hyattsville, Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 21 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Trause</u>

10501

10501

M

I

314-31-0880

Richard

11/21/61

George Washington

11/21/61

11/21/61

Francis Lach's Sons

Francis Lach's Sons

11/21/61

11/21/61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10508

CERTIFICATE OF DEATH

Reg. Dist. No.

10508

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>h-h</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel General Hospital</u>		d. STREET ADDRESS <u>Fairview Trailer Court</u>	
3. NAME OF DECEASED (Type or print) <u>Adeline</u> First <u>Prisc</u> Middle <u>Brewer</u> Last		4. DATE OF DEATH <u>September 29</u> 19 <u>61</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 30, 1887</u>
9. AGE (In years lost birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jefferson Davis Baldridge</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Gertrude Winsett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>431-05 9639</u>	
17. INFORMANT <u>Mrs Ethel Haley Laurel Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Sigmoid</u> <u>1533</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>L. G. Camp</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 3, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Linwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Paragould, Arkansas</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Connelley</u>		ADDRESS <u>Laurel, Md</u>	
24a. REC'D BY REGISTRAR <u></u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	
DATE <u>OCT 4 '61</u>			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10509		10503	
1. PLACE OF DEATH a. COUNTY Prince George's		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxan Run	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hosp.		d. STREET ADDRESS 2613 Southern Ave., S.E.	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph JULES Broches		4. DATE OF DEATH Month Day Year Sept 4 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 30, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY General Merchandise	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 579-18-5921	
17. INFORMANT Address MRS. ROTH GORMLEY 5249 43rd AV. N.W. D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 578 X DUE TO Massive Gastrointestinal Hemorrhage (b) Esophageal & gastric ulcerations (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug. 23 1961 to Sept. 4 1961, that (I) (we) lost saw the deceased alive on Sept. 4 1961, and that death occurred at 10:40 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. Samuel J. Sugar, M.D.		22b. DATE SIGNED 9-4-61	
22c. PHYSICIAN'S NAME (Type) Dr. Samuel J. Sugar, M.D.		22d. ADDRESS 5801 Baltimore Ave., Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-6-1961	23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM	23d. LOCATION (City, town, or county) (State) BLADENSBURG, MARYLAND
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, Riverdale, Md.		25a. REC'D BY REGISTRAR DATE SEP 7 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Knead

1

10510

10504

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		/ d. STREET ADDRESS 9025 Central Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Ethel (NMN) Brooke		4. DATE OF DEATH Month Day Year Sept. 5 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 Feb 1897
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James W. Beavers		14. MOTHER'S MAIDEN NAME Sarah C. Campbell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Irene Opitz, 409--57th Ave., Capitol Heights, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Renal Failure (Acute) DUE TO (c) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Many yrs.		INTERVAL BETWEEN ONSET AND DEATH 1 mo. 1 wk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 19 61, to Sept. 5 19 61, that (I) (we) last saw the deceased alive on Sept. 5 19 61, and that death occurred at 3:35 P.M. from the causes and on the date stated above.			
22a. SIGNATURE W.B. Sheer M.D.		22b. DATE SIGNED 9-5-61	
22c. PHYSICIAN'S NAME (Type) WALTER B. SHEER		22d. ADDRESS 7200 MARLBORO PIKE - WASH. 28, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/8/1961	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland Rd. Pr. Geo. Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		25a. REC'D BY REGISTRAR 51711 th St. S.E.	
25b. REGISTRAR'S SIGNATURE		DATE SEP 6 '61	

10510

CENTRAL OF MARY

10510

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10511

Reg. Dist. No. 10505

1. PLACE OF DEATH a. COUNTY Prince Goerges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR BROWN				4. DATE OF DEATH Month Day Year September 27, 1961			
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-27-1888	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY U. S. A.			
13. FATHER'S NAME William Brown				14. MOTHER'S MAIDEN NAME Viola Guy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Nestie Brown Address Bowie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Renal Disease 442X DUE TO (b) with Hypertension DUE TO (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none INTERVAL BETWEEN ONSET AND DEATH Aug. 20 1956							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 20, 1956, to Sept. 27, 1961, that I last saw the deceased alive on Sept. 27, 1961, and that death occurred at 9:25 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE G. E. Lancaster				DATE SIGNED 9/27/61			
PHYSICIAN'S NAME (Type) G. E. Lancaster				ADDRESS (Street, city or town, state) Bowie, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/30/61		22c. NAME OF CEMETERY OR CREMATORY ASCENSION CAT. CH.		22d. LOCATION (City, town, or county) (State) BOWIE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Robert J. McQuinn				24a. REC'D BY REGISTRAR ADDRESS 1820 9TH ST. N.W. WASHINGTON, D.C.		24b. REGISTRAR'S SIGNATURE DATE SEP 29 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1951

PLACE OF DEATH HOME		SEX FEMALE	
RACE WHITE		AGE 74	
DATE OF DEATH JAN 10 1951		TIME OF DEATH 10:00 AM	
PLACE OF BIRTH BALTIMORE, MD		DATE OF BIRTH JAN 10 1877	
NAME OF DECEASED MARY ANN BROWN		NAME OF FATHER JOHN BROWN	
NAME OF MOTHER SARAH BROWN		NAME OF SPOUSE JOHN BROWN	
OCCUPATION HOUSEWIFE		CAUSE OF DEATH HEART DISEASE	
MEDICAL HISTORY HYPERTENSION		PRESENT ILLNESS HEART DISEASE	
SIGNATURE OF PHYSICIAN J. B. BROWN		SIGNATURE OF DEATH REGISTRAR J. B. BROWN	
SIGNATURE OF WITNESS J. B. BROWN		SIGNATURE OF WITNESS J. B. BROWN	

MAY 10 1951

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the city or county in which the death occurred.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10512

10506

FOR STATE
HEALTH DEPT

1. PLACE OF DEATH

a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Prince George's

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

18 Oxon Run Hill

STREET ADDRESS

2607 Southern Avenue

Apt 303

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED

(Type or print)

Robert

Lawrence

Brumback Jr

4. DATE OF DEATH

Month

Day

Year

September 2,

19 61

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

☐ NEVER MARRIED ☒

☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

June 11, 1961

9. AGE (In years last birthday)

IF UNDER 1 YEAR

Month 2 Days 21

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

District of Columbia USA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Robert Lawrence Brumback Sr

14. MOTHER'S MAIDEN NAME

Joyce Ann Kite

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Address

Robert L. Brumback Sr. same as # 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

490X

DUE TO

PNEUMONIA, BILATERAL

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

Sept. 2, 1961

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

9-5-61

22c. NAME OF CEMETERY OR CREMATORY

Cedar Hill

22d. LOCATION (City, town, or country)

Suitland, Md.

(State)

23. FUNERAL DIRECTOR

ADDRESS

Lee Funeral Home - Washington D.C.

24a. REC'D BY REGISTRAR

SEP 7 '61

DATE

24b. REGISTRAR'S SIGNATURE

Arthur L. Kraus

9VVVVVVVVVV

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1

Prince George's

Chesley

Prince George's General Hospital

Robert

Lawrence

Male

White

X

June 11, 1961

2 31

District of Columbia USA

None

None

Robert Lawrence Brumback Jr

Joyce Ann Hise

None

No

Robert L. Brumback Sr. also as a

JAMES I. BORD, M.D.

7-2-61

See attached case - Washington

Sept. 2, 1961

X

X

X

X

10202

10212

Maryland

Prince George's

Oxon Hill Hill

441 308

2807 Southern Avenue

Brumback Jr

September 2,

21

1
M
077
10513
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
10507

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Walter T Burkhardt Jr				4. DATE OF DEATH Month Day Year Sept 1 19 61			
5. SEX male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 Oct. 1919	
9. AGE (In years last birthday) 41 yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Walter T. Burkhardt, Sr.				14. MOTHER'S MAIDEN NAME Mayme Ullery			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 308-10-7050			
17. INFORMANT Address 3252 Queenstown Drive - Mt. Rainier, Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.00 Cerebrovascular acc. sten. Ar DUE TO (b) Ast. Sclerosis to Ht disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic Mellitus INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from 1955 19 to Sept 1 19 61, that (I) (we) last saw the deceased alive on Sept 1 19 61, and that death occurred at 6:30 AM from the causes and on the date stated above.			
22a. SIGNATURE Dr. L. Levitsky, M.D.				22b. DATE SIGNED September 1, 1961			
22c. PHYSICIAN'S NAME (Type) Dr. L. Levitsky, M.D.				22d. ADDRESS 3408 Rhode Island Ave., Mt. Rainier, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9/5/61			
23c. NAME OF CEMETERY OR CREMATORY National Mem. Park				23d. LOCATION (City, town, or county) (State) Falls Church, Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE H. Hines Co 2901 145th NW				25a. REC'D BY REGISTRAR SEP 5 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Hines							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10514

10508

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY in 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 4450 White Hall Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Paul Edward Burnham				4. DATE OF DEATH September 19 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-18-89	
9. AGE (In years last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
13. FATHER'S NAME Harry Burnham				14. MOTHER'S MAIDEN NAME Sarah Johnson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 221-14-884			
17. INFORMANT Mrs. JOSEPH BADEN, 7314 Halleck St. District Hts., Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) GENERALIZED ARTERIOSCLEROSIS (c) 1 YEAR				INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CHRONIC PYELONEPHRITIS				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/11 , 19 61 , to 9/19 , 19 61 , that (I) (we) last saw the deceased alive on 9/19 , 19 61 , and that death occurred at 4:15 P.M. , from the causes and on the date stated above.							
22a. SIGNATURE Samuel J. N. Sugar M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9/19/61	
22c. PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR				22d. ADDRESS 4637 EASTERN AVE WASH 18 DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-23-61		23c. NAME OF CEMETERY OR CREMATORY OLD FIELDS		23d. LOCATION (City, town or county) (State) HUGHESVILLE, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 26 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

(M)

10512

10502

(1)

NO

321-14-24 Allie Joseph Brown, 1901-1978

Marshall

Farmington

Farmington

U.S.A.

Marshall, 1901-1978
Marshall, 1901-1978
Marshall, 1901-1978

Charles Marshall

Marshall, 1901-1978

Marshall, 1901-1978

The Hunt Funeral Home, Inc.,
Marshall, 1901-1978

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10515

10509

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u> c. LENGTH OF STAY in 1b <u>4 months and 23 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glenn Dale Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>66 N.Y. Ave., N.W., Apt 103</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>L.</u> Last <u>Burton</u>			4. DATE OF DEATH Month <u>9</u> Day <u>18</u> Year <u>19 61</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>2/13/89</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Melvorn Ice Cream Company</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Basil Burton</u>					
14. MOTHER'S MAIDEN NAME <u>Anna Iardella</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Unknown</u>					
16. SOCIAL SECURITY NO. <u>712-03-5013</u>		17. INFORMANT <u>Margaret E. Burton Same as # 2 (Wife)</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma, left lung, squamous cell type</u> DUE TO (b) <u>162.1</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>162.1</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> e.m. <u>19</u> p.m. <u>—</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>Washington</u> (County) <u>—</u> (State) <u>—</u>							
21. I certify that (I) (this hospital) attended the deceased from <u>4/26/61</u> to <u>9/18/61</u> , that (I) (we) last saw the deceased alive on <u>9/18/61</u> , and that death occurred at <u>4:35</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Moe Weiss</u>			22b. DATE SIGNED <u>9/18/61</u>				
22c. PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u>			22d. ADDRESS <u>Glenn Dale Hospital</u> <u>Glenn Dale, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/22/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>			
23d. LOCATION (City, town or county) <u>Washington D. C.</u>		25a. REC'D BY REGISTRAR <u>SEP 21 '61</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Guacki Son of Hattsville Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

Handwritten notes and signatures at the bottom of the page, including a large signature that appears to read "John Wood" and some illegible scribbles.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10516

10510

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. LENGTH OF STAY IN 1b 1 yr. and 2 months			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 614 N. St., N.W.			
3. NAME OF DECEASED (Type or print) Irma First Middle Last Butler				4. DATE OF DEATH 9 25 1961			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> but separated <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/4/20	
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	
11. BIRTHPLACE (County & State, or foreign country) Ga.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Moses Terrell		14. MOTHER'S MAIDEN NAME Elsie Butler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 579-16-0292		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, right lung 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Pulmonary tuberculosis, minimal; left pneumonectomy, 9/11/61; acute pyelonephritis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/25/1960 to 9/25/1961, that (I) (we) last saw the deceased alive on 9/25/1961, and that death occurred at 11 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				22b. DATE SIGNED 9/25/1961		22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.	
22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-30-61		23c. NAME OF CEMETERY OR CREMATORY Natl Harmony		23d. LOCATION (City, town or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE C. L. Kamm Sr.		25a. REC'D BY REGISTRAR DATE OCT 4 '61		25b. REGISTRAR'S SIGNATURE C. L. Kamm			

VR A15 (4)
15M 9/60

10510

10510

M

10510

10510

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10517

CERTIFICATE OF DEATH

Reg. Dist. No. 10517

1. PLACE OF DEATH a. COUNTY Prince Geo. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Hgts.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7823 Gateway Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mrs. Elizabeth Butterworth		4. DATE OF DEATH Month 9 Day 18 Year 1961	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 April 1882
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Joynson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) No (If yes, give nature of service) XXXXXX		16. SOCIAL SECURITY NO. None	
17. INFORMANT Robert Butterworth		Address Same 1 d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 7 days many years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-30-61 , 19____, to 9-18-61 , 19____, that I last saw the deceased alive on 9-17-61 , 19____, and that death occurred at 7:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7200 Marlboro Pike S. E. DATE SIGNED 9-18-61 ACTUAL SIGNATURE W.B. Sheer M.D. PHYSICIAN'S NAME (Type) Walter B. Sheer M. D. Washington 28, D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 20 Sept. '61	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.	22d. LOCATION (City, town, or county) (State) Bladensburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		ADDRESS 300-4th St. N.E.D.C.	24a. REC'D BY REGISTRAR DATE SEP 20 '61
		24b. REGISTRAR'S SIGNATURE Arthur S. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

14

NAME OF DECEASED: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
MARRIAGE: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF REGISTRAR: [illegible]

DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
EDUCATION: [illegible]
MARRIAGE: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF REGISTRAR: [illegible]

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10518

10512

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 19 HRS 14 MIN d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) US AIR FORCE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRYANS ROAD d. STREET ADDRESS PARK LOT 54, BRYANS ROAD TRAILER/ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BARBARA First JEAN Middle CHOQUETTE Last		4. DATE OF DEATH SEPTEMBER 28 19 61 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 SEPTEMBER 1961
9. AGE (In years last birthday) yrs. 19		10. IF UNDER 1 YEAR Months 19 Days 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (County & State, or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? UNITED STATES			
13. FATHER'S NAME PHILIP H CHOQUETTE		14. MOTHER'S MAIDEN NAME JOYCE I HARRISON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) ANOXIA DUE TO (b) ATELECTASIS DUE TO (c) PREMATURITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 19 HRS 14 MIN 19 HRS 14 MIN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 27 SEPT 19 61 to 28 SEPT 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 28 SEPT 19 61 , and that death occurred at 645A M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Richard P. Malsan</i> M.D.		22b. DATE SIGNED 28 SEPTEMBER 1961	
22c. PHYSICIAN'S NAME (Type) RICHARD P MALSAN, Capt USAF MC		22d. ADDRESS USAF HOSP, ANDREWS AFB, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>A.C. Morgan</i>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 2 '61	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

VR A15 (4)
15M 9/60

2050212XV0

M

5

1

10312

10312

RECEIVED

RECEIVED

US AIR FORCE HOSPITAL

107 24, BAYARD ROAD, TAILOR

BARBARA

CHOCQUETTE

SEPTEMBER 24

YEMATE CARABIAN

27 SEPTEMBER 1961

HOME

HOME

MARYLAND

UNITED STATES

WILLIE H CHOCQUETTE

JOYCE I HARRISON

NO

HOME

ALMA

ATLANTIC

TRINIDAD

28 SEPT

27 SEPT

28 SEPT

Richard E. Harrison

RICHARD E HARRISON, CAPT USAF, MC NEAL HOSP, WASHINGTON, DC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10519

10513

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Adelphi</u> c. LENGTH OF STAY IN b. <u>2 mo. 4 da</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Paint Branch Nursing Home</u>												2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <u>MARYLAND</u> COUNTY <u>PR. Geo.</u> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u> g. STREET ADDRESS <u>1727 Central Ave.</u> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Virginia</u> Last <u>Collins</u>						4. DATE OF DEATH Month <u>Sept.</u> Day <u>21</u> Year <u>1961</u>																							
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 29, 1868</u>		9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>																			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>						11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>James E. Harry</u>						14. MOTHER'S MAIDEN NAME <u>Sarah Queen</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Paint Branch Nursing Home Records</u> Address <u> </u>																	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> 331X } DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CEREBRAL VASCULAR ACCIDENT</u> (a), stating the underlying cause last. } DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>48 HRS.</u>																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERAL DEBILITY</u>																								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>						20f. (City or town) (County) (State)											
21. I certify that (I) (the hospital) attended the deceased from <u>9-19</u> , 19 <u>61</u> , to <u>9-21</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>9-19</u> , 19 <u>61</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.																													
22a. SIGNATURE <u>Morrill C. Quinnam Jr.</u> M.D.												ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED <u>9-21-61</u>											
22c. PHYSICIAN'S NAME (Type) <u>MORRILL C. QUINNAM JR.</u>												22d. ADDRESS <u>704 - DEVINSHIRE RD. TAKOMA PARK MD</u>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						23b. DATE THEREOF <u>Sept. 23-61</u>						23c. NAME OF CEMETERY OR CREMATORY <u>St. Matthews Cem.</u>						23d. LOCATION (City, town or county) (State) <u>Seat Pleasant MD</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u>												ADDRESS <u>1661 6800 Hope</u>						25a. REC'D BY REGISTRAR <u>SEP 25 '61</u>						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>					

James E. Harry
 None
 Point Branch Nursing Home
 Sarah Queen
 District of Columbia
 None
 F. W.
 Alice Virginia Collins
 Sept 21 61
 Point Branch Nursing Home
 Beat Stewart
 Miriam

GENERAL INQUIRY

Mary G. Green
 Point Branch Nursing Home
 Sept 21 61
 Point Branch Nursing Home
 Beat Stewart
 Miriam

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10520

10514

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillcrest Hgts				c. LENGTH OF STAY IN 1b 9 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5807--25th Ave. S.E.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights			
				d. STREET ADDRESS 5807--25th Ave., S.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JULIA Middle C. Last COOKE				4. DATE OF DEATH Month Sept. Day 25th Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 26, 1892	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Virginia	
10b. KIND OF BUSINESS OR INDUSTRY Domestic		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Kendell		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Henry G. Cooke				Address Same as # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic heart disease DUE TO (b) 443 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1960 to Sept 25, 1961, that (I) (we) last saw the deceased alive on Sept 25, 1961, and that death occurred at 3 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Frank J. Talbot				22b. DATE SIGNED 9/25/61		22c. PHYSICIAN'S NAME (Type) Frank J. Talbot	
22d. ADDRESS 4307 Branch Ave 21 DC				22e. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 28 1961		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Adams Bros				ADDRESS 1661--Good Hope Rd., SE Washington 20 DC			
25a. REC'D BY REGISTRAR SEP 28 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



10520

10513

Prince George's

Maryland

Mr. Geo.

Millersville Heights

9 yrs.

Millersville Heights

2807--28th Ave. S.E.

2807--28th Ave. S.E.

JULIA

COOKS

Sept. 25th

White

Female

April 20, 1892

69

Housewife

Domestic

Virginia

USA

John Randall

Harry

Henry C. Cooke

Washington, D.C.



Bureau

Sept. 20 1901

Robert Hill Company

Baltimore, Maryland

Washington 20 DC

Sept 27 1901

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10515

1
FOR STATE
HEALTH DEPT.

10521

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakton	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Thomas Cooper		4. DATE OF DEATH September 1, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 13, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Merchandise	
11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A. Cooper		14. MOTHER'S MAIDEN NAME Dora Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Marion L. Cooper		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure			
DUE TO (b) Arteriosclerotic Heart Disease			
DUE TO (c) Diabetes several years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED Sept. 1, 1961	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5 SEPT. 1961	22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	22d. LOCATION (City, town, or country) (State) SUITLAND MD.
23. FUNERAL DIRECTOR Linaldi Funeral Home, Inc		24a. REC'D BY REGISTRAR SEP 5 '61	
ADDRESS 816 Apt. N.E. DC		24b. REGISTRAR'S SIGNATURE John S. House	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-300
10-111

၂၀၂၁

Received 12.12.03

saibendoren

1912 1700

Alabama - never before

NAME: _____

1967

1
M
050
1
2
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 2 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF HOSPITAL, ANDREWS AFB						2. USUAL RESIDENCE (Where deceased lived, if institution, give name before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND d. STREET ADDRESS 4799 WHELLER HILLS ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JOHN SAMUEL COX III			4. DATE OF DEATH Month SEPTEMBER Day 22 Year 19 61								
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 20 SEPTEMBER 61		9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE				11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME JOHN S COX				14. MOTHER'S MAIDEN NAME LINDA E MOORE							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT HOSPITAL RECORD		Address SAME AS ITEM #1					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital atelectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) Prematurity (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)								INTERVAL BETWEEN ONSET AND DEATH 24 hrs 2 days			
21. I certify that (I) (this hospital) attended the deceased from 20 SEPT , 19 61 , to 22 SEPT , 19 61 , that (I) (we) last saw the deceased alive on 22 SEPT , 19 61 , and that death occurred at 240A , from the causes and on the date stated above.								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
22. SIGNATURE Arnold A. Abram 22c. PHYSICIAN'S NAME (Type) ARNOLD A ABRAMQ CAPT USAF MC						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS USAF HOSP, ANDREWS AFB, MD		22b. DATE SIGNED 22 SEPT 61			
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF 9/24/61		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl		23d. LOCATION (City, town or county) (State) Arlington Va					
24. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home						25a. REC'D BY REGISTRAR DATE OCT 2 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

2050191XV2

(M)

(C)

(4)

10255

PHILIP C. BROWN

ARMED AIR FORCE BASE 2 DAYS

USAF HOSPITAL, ANDREWS AFB

JOHN

DANIEL

COX III

SEPTEMBER 24

14

NAME

CAUCASIAN

20 SEPTEMBER 01

3

HOME

HOME

MARYLAND

UNITED STATES

JOHN & COX

LINDA E MOORE

NO

HOME

HOSPITAL RECORD

NAME AS LISTED

Handwritten notes:
10/25/55
10/26/55

Handwritten notes:
10/25/55
10/26/55

12

13

14

15

16

17

USAF HOSPITAL, ANDREWS AFB, MD

ARMED AIR FORCE BASE, ANDREWS AFB, MD

Handwritten notes at bottom:
10/25/55
10/26/55
10/27/55
10/28/55
10/29/55
10/30/55
10/31/55
11/1/55
11/2/55
11/3/55
11/4/55
11/5/55
11/6/55
11/7/55
11/8/55
11/9/55
11/10/55
11/11/55
11/12/55
11/13/55
11/14/55
11/15/55
11/16/55
11/17/55
11/18/55
11/19/55
11/20/55
11/21/55
11/22/55
11/23/55
11/24/55
11/25/55
11/26/55
11/27/55
11/28/55
11/29/55
11/30/55
12/1/55
12/2/55
12/3/55
12/4/55
12/5/55
12/6/55
12/7/55
12/8/55
12/9/55
12/10/55
12/11/55
12/12/55
12/13/55
12/14/55
12/15/55
12/16/55
12/17/55
12/18/55
12/19/55
12/20/55
12/21/55
12/22/55
12/23/55
12/24/55
12/25/55
12/26/55
12/27/55
12/28/55
12/29/55
12/30/55
12/31/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10523

CERTIFICATE OF DEATH

10517

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Landover Hills d. STREET ADDRESS 3605 64th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Melinda Sue Cox First Middle Last Female White 5. SEX 7545 6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None		4. DATE OF DEATH September 9 1961 Month Day Year 9. AGE (In years last birthday) July 22, 1961 --- Yrs. 1 19 11. BIRTHPLACE (County & State, or foreign country) Cheverly, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Austin Eugene Cox		14. MOTHER'S MAIDEN NAME Mell Laura Louise Conrad	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion and Edema DUE TO (b) Subaortic Stenosis DUE TO (c) Congenital Heart Disease (Hypoplasia of ventricle) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 7545 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Since birth	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) no injury		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) no injury	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) birth		20f. (City or town) (County) (State) Sept 9 1961	
21. I certify that (I) (this hospital) attended the deceased from Aug 26 1961 11:45 to Sept 9 1961 6:00 that (I) (we) last saw the deceased alive on Aug 26 1961 and that death occurred at 11:45 from the causes and on the date stated above.			
22a. SIGNATURE Milos A. Jansa, M.D. M.D.		22b. DATE SIGNED September 11, 1961	
22c. PHYSICIAN'S NAME (Type) Milos A. Jansa, M.D.		22d. ADDRESS 7403 Varnum Street, Landover Hills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/13/61	
23c. NAME OF CEMETERY OR CREMATORY Pleasant Hill		23d. LOCATION (City, town or county) (State) Glasgow Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		25a. REC'D BY REGISTRAR SEP 13 '61	
ADDRESS Hyattsville, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

2077324xv5

M
C
I

10017

10017

(Hippocampus (Hippocampus))

the (Hippocampus)

left 1

left 1

left 1

6

Glasgow

Birmingham

1873

1873

Hartsville, Maryland (1873)

Francis Grubb & Sons

10524

10518

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>	
c. LENGTH OF STAY IN 1b <u>5 mos.</u>		d. STREET ADDRESS <u>HARBOR ROAD 20X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>416 CIRCLE AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM (NMI) CRANMER</u>		4. DATE OF DEATH Month Day Year <u>SEPT. 4 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 24 1884</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY CRANMER</u>		14. MOTHER'S MAIDEN NAME <u>EMMA HUSK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>1105 Glee Ring, 418 Circle Ave, Takoma Park Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER Prostate with metastases.</u> DUE TO (b) <u>177X</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u>metastases.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JULY 1960</u> to <u>Sept 4 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 4 1961</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Ernest A. Sarao</u>		22b. DATE SIGNED <u>Sept 4, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>ERNEST A. SARAO, M.D.</u>		22d. ADDRESS <u>TAKOMA PARK, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEPT 7, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WHIVET CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ST. MICHAELS MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A. Hambleton Harrison, A. Michael</u>		ADDRESS	
25a. REC'D BY REGISTRAR <u>SEP 7 61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

md

(M)

(1)

10524

CERTIFICATE OF DEATH

10524

NAME (GEOFFREY) GEORGE

RESIDENCE (10) ST. JAMES

DATE OF BIRTH (1910)

DATE OF DEATH (1910)

PLACE OF BIRTH (1910)

CAUSE OF DEATH (1910)

SIGNATURE (1910)

WITNESSES (1910)

NOTARIES (1910)

REGISTRATION (1910)

FILE NO. (1910)

DATE OF ENTRY (1910)

PLACE OF ENTRY (1910)

REMARKS (1910)

SIGNATURE (1910)

WITNESSES (1910)

NOTARIES (1910)

REGISTRATION (1910)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10525

10519

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clinton		c. LENGTH OF STAY IN 1b X Brandywine	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4 Southern Md. Hospital Center		d. STREET ADDRESS 1 Rt. 1 Box 187	
3. NAME OF DECEASED (Type or print) Wilbert M.		4. DATE OF DEATH CUTLER 9 22 1961	
5. SEX M. 6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH April 3 1904		9. AGE (In years last birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY construction	
11. BIRTHPLACE (County & State, or foreign country) Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Cutler		14. MOTHER'S MAIDEN NAME Bertha Muri	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 479 05 1298	
17. INFORMANT Edwin Paul Cutler, Takoma Park, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction. 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 3 days 4 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. None 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 17, 1961 to Sept 22, 1961 , that (I) (we) last saw the deceased alive on Sept 19, 1961 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Alfred R. Lapan		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) ALFRED R. LAPAN		22d. ADDRESS CLINTON, MD	
22b. DATE 22		22a. DATE SIGNED Arthur S. Hanes	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9/25/61	
23c. NAME OF CEMETERY OR CREMATORY Immanuel Church Cemetery		23d. LOCATION (City, town or county) (State) Brandywine, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home		ADDRESS Waldorf, Md.	
25a. REC'D BY REGISTRAR SEP 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

10519

10524

M

1

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.
SEP 27 1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Suitland Md.</i>		c. LENGTH OF STAY IN 1b <i>41 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suitland Nursing Home</i>		d. STREET ADDRESS <i>15017-26th Ave., S.E.</i>	
3. NAME OF DECEASED (Type or print) First <i>Myrtle</i> Middle <i>C.</i> Last <i>Davidson</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>16</i> Year <i>1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 19, 1917</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dr's Office</i>	11. BIRTHPLACE (State or foreign country) <i>North Dakota</i>
13. FATHER'S NAME <i>William Baker</i>		14. MOTHER'S MAIDEN NAME <i>Thelma Horst Meyer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Lloyd Davidson</i>		Address <i>5017-26th Ave. Hillcrest Heights Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lupus Erythematosus, disseminated</i> 705.5 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>15 months</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>May 7, 1961</i> to <i>Sept. 16, 1961</i> , that (I) (we) last saw the deceased alive on <i>9-15-61</i> , and that death occurred at <i>6:25</i> M, from the causes and on the date stated above.	
22a. SIGNATURE <i>David S. Gordon</i>		22b. DATE SIGNED <i>Sept. 16-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>David S. Gordon</i>		22d. ADDRESS <i>5731 23d Parkway, Hillcrest Hgts, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9-19-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Catholic Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Hazelton North Dakota</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Sammons Bros.</i>		25a. REC'D BY REGISTRAR <i>1661-20th Ave WASH, 20 DC</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles S. Kneass</i>		DATE <i>SEP 20 '61</i>	

(M)

(I)

(141)

10528

10528

Prince Georges

Georgian

2-11-1914

W. H. H. H.

W. H. H. H.

2-11-1914

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10527 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institutional, include date of admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY in 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		d. STREET ADDRESS 5114-70th Place	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Joseph King Davis				4. DATE OF DEATH Month September Day 4 Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18, 1890	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fisherman		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Louis Davis				14. MOTHER'S MAIDEN NAME Mary Wilherson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address Mrs. Agnes G. Meyer, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the left lung DUE TO (b) 163X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 9/4/61 Address (Street, city, town, or county)							
ACTUAL SIGNATURE James I. Boyd		M.D. DATE SIGNED 9/4/61					
EXAMINER'S NAME (Type) James I. Boyd							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/6/61	22c. NAME OF CEMETERY OR CREMATORY Joy Chapel		22d. LOCATION (City, town, or county) (State) Hollywood, Maryland			
23. FUNERAL DIRECTOR ADDRESS W. Clarke Mattingley Leonardtown, Maryland				24a. REC'D BY REGISTRAR SEP 8 '61		24b. REGISTRAR'S SIGNATURE W. C. M.	

75201

15301

1900

Dmily, 18K

REVISED

Illegible text.

100000

•

615

Accepted for publication 12 November 2003

5.

1980-1981

50178

Analysis

A.B.U.

Charles Louis Davis

May Wilkerson

Continuation of the left lung

James I. Boyd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10528 Item 23 Film 6297 10/2/61 mh											
10522											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 33 HOURS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF HOSPITAL, ANDREWS AFB						2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY DISTRICT OF COLUMBIA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 2137 SUITLAND TERRACE SE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last CONNIE LOU DEESE						4. DATE OF DEATH Month Day Year Sept. 20 1961					
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 SEPTEMBER 1961		9. AGE (in years last birthday) yrs. 33		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (County & State, or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME MARVIN FARRELL DEESE						14. MOTHER'S MAIDEN NAME KO PU YONG					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT FATHER		Address SAME AS ITEM #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Vasomotor + Resp Collapse 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Chronic Hypoxia (a), stating the underlying cause test. (c) Quaternary Cerebral Anoxia 20 to Birth Trauma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Tesimally		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 20 Sept. 1961 , to 20 Sept. 1961 , that (I) (we) last saw the deceased alive on 20 Sept 1961 , and that death occurred at 1318 M, from the causes and on the date stated above.											
22a. SIGNATURE Hestley D. Stepp M.D.						ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Hestley D. Stepp, CAPT USAF MC USAF Hosp. Andrews, Maryland.						22d. ADDRESS 19 & E. St., SE, Wash., D. C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF Sept. 22, 1961		23c. NAME OF CEMETERY OR CREMATORY D. C. Morgue		23d. LOCATION (City, town or county) (State) 19 & E. St., SE, Wash., D. C.			
24 FUNERAL DIRECTOR'S SIGNATURE						ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 25 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Knapp	

2250241XV5



10558

BRIDGE STREET

WASHINGTON

31 JUNE

ANDREWS AIR FORCE BASE

1717 BULLARD TRUNK RD

1000 HOSPITAL, ANDREWS AFB

DEGREE

100

CONVICT

CAUCASIAN

ETHNIC

18 SEPTEMBER 1951

X

MARYLAND

NONE

NONE

NO PU YORK

MARVIN BARRELL DENNIS

FATHER

NONE

NO

UNITED STATES

PAGE 05 ITEM 01

20877

20877

20877

20877

20877

20877

20877

20877

20877

20877

1
FOR STATE
HEALTH DEPT.

M

is necessary, give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10529 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10529 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Dead on arrival		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brentwood			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 3800 Bunker Hill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Denise Middle Dorine Last Detorrie				4. DATE OF DEATH Month September Day 26 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 29/52 8 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Joseph Detorrie Jr				14. MOTHER'S MAIDEN NAME Geraldine Campbell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Frank Joseph Detorrie, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 744.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Amyotonia (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd M.D. EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED Sept. 26, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 28 SEPT. 1961		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		22d. LOCATION (City, town, or country) (State) WASHINGTON D.C.	
23. FUNERAL DIRECTOR RINALDI FUNERAL HOME				ADDRESS 816 H ST. N.E. DC 2		24a. REC'D BY REGISTRAR DATE SEP 28 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Huns			



Prinos George's General Hospital 5800 E. 11th Ave
Prinos George's General Hospital 5800 E. 11th Ave
Prinos George's General Hospital 5800 E. 11th Ave

Prinos George's General Hospital 5800 E. 11th Ave
Prinos George's General Hospital 5800 E. 11th Ave
Prinos George's General Hospital 5800 E. 11th Ave

Prinos George's General Hospital 5800 E. 11th Ave
Prinos George's General Hospital 5800 E. 11th Ave
Prinos George's General Hospital 5800 E. 11th Ave

Prinos George's General Hospital 5800 E. 11th Ave
Prinos George's General Hospital 5800 E. 11th Ave
Prinos George's General Hospital 5800 E. 11th Ave

Prinos George's General Hospital 5800 E. 11th Ave
Prinos George's General Hospital 5800 E. 11th Ave
Prinos George's General Hospital 5800 E. 11th Ave

Prinos George's General Hospital 5800 E. 11th Ave
Prinos George's General Hospital 5800 E. 11th Ave
Prinos George's General Hospital 5800 E. 11th Ave

Prinos George's General Hospital 5800 E. 11th Ave
Prinos George's General Hospital 5800 E. 11th Ave
Prinos George's General Hospital 5800 E. 11th Ave

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Item 18 Film 1297 10-2 MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10530 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10524											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 29 Seat Pleasant				d. STREET ADDRESS 6807 F Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Francis Howard Dore						4. DATE OF DEATH Month Day Year September 18 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 26, 1922		9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier				10b. KIND OF BUSINESS OR INDUSTRY Giant Foods		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Dore Sr						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW 11		17. INFORMANT Mrs Betty Eileen Dore, same as # 2				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 872.9 CARDIAC ARREST Conditions, if any, which gave rise to immediate cause (b) (Pending) Ingestion of Salicylates (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. - p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 9/18/61 Address (Street, city, town, or county)											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/21/1961		22c. NAME OF CEMETERY OR CREMATORY Arlington		22d. LOCATION (City, town, or country) Ft Myer		(State) Va			
23. FUNERAL DIRECTOR ADDRESS Lee Funeral Home, 300 4th N.E. Wash. D.C.						24a. REC'D BY REGISTRAR DATE SEP 20 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MEDICAL CERTIFICATION

(M)

Overly

D.C.A.

Staff Sergeant

Prince George's General Hospital

Room 1 Street

Prince George's

Dora

Department Jan 61

Male

White

May 26, 1922

Canister

Prince George's

Ohio

U.S.A.

Charles Dora B.

Unknown

Mr Betty Ellen Dora, care of R.R.

James I. Boyd

XX

5/18/61

X

X

X

X

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>10531</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div> <div>10525</div> </div> </div> <div> <div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> </div> <div> <div>2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</div> <div>a. STATE</div> </div> </div>											
<div> <div>Prince George's</div> <div>MARYLAND</div> </div>				<div> <div>Delaware</div> <div>Kent</div> </div>							
<div> <div>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>Riverdale</div> </div>				<div> <div>c. LENGTH OF STAY IN 1b</div> <div>1 hour</div> </div>				<div> <div>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>Dover</div> </div>			
<div> <div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> <div>Leland Memorial Hospital</div> </div>											
<div> <div>3. NAME OF DECEASED (Type or print)</div> <div>First Middle Last</div> <div>Frederick Charles Dowd Jr</div> </div>				<div> <div>4. DATE OF DEATH</div> <div>Month Day Year</div> <div>September 23, 19 61</div> </div>				<div> <div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div>			
<div> <div>5. SEX</div> <div>Male</div> </div>		<div> <div>6. COLOR OR RACE</div> <div>White</div> </div>		<div> <div>7. MARRIED</div> <div><input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> </div>		<div> <div>8. DATE OF BIRTH</div> <div>July 27, 1900</div> </div>		<div> <div>9. AGE (In years last birthday)</div> <div>61 yrs.</div> </div>		<div> <div>IF UNDER 1 YEAR</div> <div>Months Days Hours Min.</div> </div>	
<div> <div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Contractor</div> </div>				<div> <div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>Construction</div> </div>				<div> <div>11. BIRTHPLACE (State or foreign country)</div> <div>Massachusetts</div> </div>		<div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div> </div>	
<div> <div>13. FATHER'S NAME</div> <div>Fred E. Dowd</div> </div>				<div> <div>14. MOTHER'S MAIDEN NAME</div> <div>Alexinia Smith</div> </div>				<div> <div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give year or dates of service)</div> <div>No</div> </div>			
<div> <div>16. SOCIAL SECURITY NO.</div> <div>064-18-6639</div> </div>				<div> <div>17. INFORMANT</div> <div>Roland P. Trader, Dover, Delaware</div> </div>				<div> <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)</div> <div>420.1</div> <div>DUE TO</div> <div>Coronary occlusion</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>(b)</div> <div>Coronary artery disease</div> <div>DUE TO</div> <div>(c)</div> </div>			
<div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> </div>											
<div> <div>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</div> </div>				<div> <div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div> </div>							
<div> <div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour a.m. p.m.</div> <div>19</div> </div>		<div> <div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div> </div>		<div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> </div>		<div> <div>20f. (City or town)</div> <div>(County)</div> <div>(State)</div> </div>		<div> <div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div>			
<div> <div>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div> </div>											
<div> <div>ACTUAL SIGNATURE</div> <div>James I. Boyd</div> </div>				<div> <div>CHIEF MEDICAL EXAMINER</div> <div>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></div> <div>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></div> </div>				<div> <div>DATE SIGNED</div> <div>9/24/61</div> </div>			
<div> <div>EXAMINER'S NAME (Type)</div> <div>James I. Boyd</div> </div>				<div> <div>Address (Street, city, town, or county)</div> </div>							
<div> <div>22a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div> </div>		<div> <div>22b. DATE THEREOF</div> <div>9-27-1961</div> </div>		<div> <div>22c. NAME OF CEMETERY OR CREMATORY</div> <div>West View Cemetery</div> </div>		<div> <div>22d. LOCATION (City, town, or county)</div> <div>Atlanta, Georgia</div> </div>		<div> <div>23. FUNERAL DIRECTOR</div> <div>W.W. Chambers 5801 Cleveland Ave, Riverdale, Md.</div> </div>		<div> <div>24. REC'D BY REGISTRAR</div> <div>DATE SEP 27 '61</div> </div>	
<div> <div>24b. REGISTRAR'S SIGNATURE</div> <div>Arthur S. Harris</div> </div>											

M

I

Prince George's

Delaware

Riverdale

1 hour

Dover

Leland Memorial Hospital

221 South Governors Avenue

Fredrick

Charles

Dowd Jr

Washington

Male

White

July 27, 1900

Contractor

Construction

Massachusetts

Fred A. Bond

Alexander Allen

Rolland P. Tabor, Dover, Delaware

Company conclusion

Company every disease

James I. Bond

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

10532

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Sacred Heart Home</i>		d. STREET ADDRESS <i>0210-J</i>	
3. NAME OF DECEASED (Type or print) First <i>Eleanor</i> Middle <i>Mary</i> Last <i>Duke</i>		4. DATE OF DEATH Month <i>September</i> Day <i>7</i> Year <i>19 61</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-13-1872</i>
9. AGE (In years last birthday) <i>89</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph J. Turner</i>		14. MOTHER'S MAIDEN NAME <i>Virginia Mumford</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Sacred Heart Home, Hyattsville, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY THROMBOSIS & MYOCARDIAL INFARCTION</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ARTERIOSCLEROTIC HEART DISEASE</i> DUE TO (c) <i>DIABETES MELLITUS</i> INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i> <i>8 years</i> <i>10 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>PAGEY'S DISEASE</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>9-1</i> , 19 <i>53</i> , to <i>9-7</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>9-7</i> , 19 <i>61</i> , and that death occurred at <i>7:00</i> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Thomas F Collins</i>		22b. DATE SIGNED <i>9-7-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>THOMAS F COLLINS</i>		22d. ADDRESS <i>322 - H - AVE</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>9-11-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 13 '61</i>	
ADDRESS <i>5305 Harford Rd.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

100000
A-H

100000

(A)

(1)



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10533

Item 8 Film C297 10/3/61 mh

10527

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Pr. Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherley</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Morningside</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince George's Gen. Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>NORMA</i> Middle <i>V</i> Last <i>Eberle</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>27</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1890</i>
9. AGE (In years last birthday) <i>70</i> yrs.		10. IF UNDER 1 YEAR Months <i>70</i> Days <i>70</i> Hours <i>70</i> Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>HARVEY L. BAHR</i>		14. MOTHER'S MAIDEN NAME <i>Annie M. Edwards</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>578-12-2947</i>	
17. INFORMANT <i>Kenneth A. Eberle</i>		Address <i>SAME AS #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> DUE TO <i>Azotemia - Severe</i> (b) <i>Chronic Pyelonephritis</i> (c) <i>Hypertensive arteriosclerotic heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>2 wks, 10-8 yrs, 10 yrs</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 26</i> to <i>Sept 27</i> 19 <i>61</i> that (I) (we) last saw the deceased alive on <i>Sept 26</i> 19 <i>61</i> , and that death occurred at <i>Sept 27</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Sidney W. Lowry</i>		22b. DATE SIGNED <i>Sept 27, 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>Sidney W. Lowry</i>		22d. ADDRESS <i>7200 Marlboro Pike SE District Heights MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>9-30-61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Washington Natl</i>	23d. LOCATION (City, town, or county) (State) <i>Southland MD</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>James Bros.</i>		25a. REC'D BY REGISTRAR <i>SEP 29 '61</i>	
ADDRESS <i>1661 - Good Hope Rd SE Wash DC</i>		25b. REGISTRAR'S SIGNATURE <i>Charles S. Hines</i>	

1553

(M)

10557
The following is a list of the names of the persons who have been
admitted to the hospital since the last report was made.
The names are given in alphabetical order of the last name.
The date of admission is given in parentheses after the name.
The name of the physician who attended the patient is given in
parentheses after the date of admission.
The name of the hospital is given in parentheses after the name of the
physician.
The name of the city is given in parentheses after the name of the
hospital.
The name of the state is given in parentheses after the name of the
city.
The name of the country is given in parentheses after the name of the
state.
The name of the continent is given in parentheses after the name of the
country.
The name of the world is given in parentheses after the name of the
continent.

1 (M) 10534 10528

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fairmont Heights d. STREET ADDRESS 716 61st Ave. N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert Ellis				4. DATE OF DEATH September 28, 1961			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/5/96	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (County & State, or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Elizabeth Bond			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) yes		16. SOCIAL SECURITY NO. WWH		17. INFORMANT Evie Ellis Address 716 61st Ave N.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Infarction Rk 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertens. Arsk. Sclerosis Ht dis. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sep 26 to Sep 28 , 19 61 , that (I) (we) last saw the deceased alive on Sep 28 , 19 61 , and that death occurred at 6:25 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Samuel J. N. Sugar M.D.				ATTENDING PHYS. <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Samuel J. N. Sugar				22d. ADDRESS 4637 Eastern Avenue, Washington 18, D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) 10-4-61		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat.		23d. LOCATION (City, town or county) (State) Arlington Va	
24. FUNERAL DIRECTOR'S SIGNATURE Henry Washington ADDRESS 4925 Ream Ave NE				25a. REC'D BY REGISTRAR DATE OCT 4 '61		25b. REGISTRAR'S SIGNATURE William S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

10238

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY in 1b

Dead on arrival

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, give address before admission)

a. STATE

Maryland

b. COUNTY

Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hyattsville

d. STREET ADDRESS

3602 Longfellow Street

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

Julia

Middle

Marie

Last

Facer

4. DATE OF DEATH

Month

September

Day

2, 1961

5. SEX

Female

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

December 23, 1889

9. AGE (In years last birthday)

71 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Examiner

10b. KIND OF BUSINESS OR INDUSTRY

U.S. Gov't
Bur. Engraving

11. BIRTHPLACE (State or foreign country)

Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Ferdinand Estler

14. MOTHER'S MAIDEN NAME

Julia Newman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service)

No

None

No

Julia L. Yeabower

Same as #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

443X

DUE TO

Acute Congestive Heart Failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Hypertensive heart Disease

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Obesity Weighed about 400 pounds

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE

James I. Boyd

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

September 2, 1961

EXAMINER'S NAME (Type)

JAMES I. BOYD, M.D.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

9/5/61

22c. NAME OF CEMETERY OR CREMATORY

Fort Lincoln Cemetery

22d. LOCATION (City, town, or country)

Bladensburg

Maryland

23. FUNERAL DIRECTOR

ADDRESS

Walter W. Deal Funeral Home 4812 Ga. Ave. N.W.

24a. REC'D BY REGISTRAR

SEP 5 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Kline

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 22 hours after death.

4820

Primo Götze

2000

U. S. GOVERNMENT PRINTING OFFICE

U.S. GOVERNMENT PRINTING OFFICE

U.S. DEPARTMENT OF AGRICULTURE

Hyperbolic heat conduction

JAMES I. BOYD, M.D.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10536 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10530

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington, 28 D.C.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Conrad Middle Elmer Last Faunce, Sr.				4. DATE OF DEATH Month September Day 8 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Month August Day 10 Year 1906	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Conrad Faunce				14. MOTHER'S MAIDEN NAME Emma Goddard			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 577-03-8846			
17. INFORMANT Baulah M. Faunce				Address Same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INFARCT, HEART 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO SEVERE, OCCLUSIVE CORONARY ATHEROSCLEROSIS DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9-11-1961		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or country) (State) Suitland Md	
23. FUNERAL DIRECTOR Robert A. Mattingly		ADDRESS Wash 3 D C		24a. REC'D BY REGISTRAR SEP 13 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

1. The first of these is the fact that the

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

TABLE 1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1
FOR STATE
HEALTH DEPT.

(M)
097
(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
10537 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10531												
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly DOA						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington 47 X 3						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital						d. STREET ADDRESS 1326 G Street N.E.						
3. NAME OF DECEASED (Type or print) First Middle Last Alonza Ferguson						4. DATE OF DEATH Month Day Year Sept 19 1961						
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1911		9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Construction				11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No						16. SOCIAL SECURITY NO. Mrs Mamie Ferguson, same as # 2						
17. INFORMANT Address												
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE James I. Boyd						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) James I. Boyd						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 9/19/61						
						Address (Street, city, town, or county)						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 9/23/1961		22c. NAME OF CEMETERY OR CREMATORY Calvary Baptist Church			22d. LOCATION (City, town, or country) Farmville, Virginia				
23. FUNERAL DIRECTOR Alex S. Pope						ADDRESS 414 15th. St. S. E.			24a. REC'D BY REGISTRAR DATE SEP 21 '61		24b. REGISTRAR'S SIGNATURE Arthur S. House	

(M)

(I)

10331

10331

Division of Criminal

George's

Division

10331

Division

George's

Division

Division

Division

U.S.A.

Division

Division

Division

Division

Division

Division

Division

Division

Division

Division

Division

Division

Division

Division

Division

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10538

10532

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN It 7 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) US AIR FORCE HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY DISTRICT OF COLUMBIA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 2427 ALABAMA AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ALESSANDRA CAROL FRANCIS				4. DATE OF DEATH Month Day Year SEPTEMBER 18 1961					
5. SEX FEMALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 SEPTEMBER 1961		9. AGE (In years last birthday) yrs. 7 IF UNDER 1 YEAR Months Days Hours Min.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME MILLARD MURRAY FRANCIS				14. MOTHER'S MAIDEN NAME AUDREY WAGNER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT HOSPITAL CHART Address SAME AS ITEM #1			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Primary Pulmonary Atelectasis DUE TO (b) Immaturity Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 7 days 7 days									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10 SEPT 1961 to 18 SEPT 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 18 SEPT 1961 , and that death occurred at 515A , from the causes and on the date stated above. 22e. SIGNATURE Nicholas P. Haritos M.D. 22c. PHYSICIAN'S NAME (Type) NICHOLAS P HARITOS, Capt USAF MC 22d. ADDRESS USAF HOSP, ANDREWS AFB, WASH 25 DC 22b. DATE SIGNED 18 SEPT 61 25e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Arthur S. Francis									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 9-20-61		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION (City, town or county) (State) ARLINGTON VA.	
24 FUNERAL DIRECTOR'S SIGNATURE B. F. Taylor				ADDRESS 909 6TH ST. N.W.		25e. REC'D BY REGISTRAR SEP 21 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Francis	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

2050233XV1

232

1001

10033

(M)
(O)

DEPARTMENT OF JUSTICE

DEPARTMENT OF JUSTICE

WASHINGTON

WASHINGTON, D.C. 20535

1400 AARON AVENUE

1400 AARON AVENUE

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

(I)

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

Handwritten notes and signatures

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

1
FOR STATE
HEALTH DEPT.

TO DEFECT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

10539
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10533

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chapel Oaks			
c. LENGTH OF STAY IN 1b DOA				d. STREET ADDRESS 5800 Linden			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Louella W. Freeman		4. DATE OF DEATH September 12 19 61		5. SEX Female		6. COLOR OR RACE Colored	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH October 2, 1900		9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Mandy Wyck			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Charles L. Freeman, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Cardiovascular renal disease DUE TO (c) 442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd		DATE SIGNED 9/13/61					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/16/61		22c. NAME OF CEMETERY OR CREMATORY NATIONAL MEMORIAL PARK		22d. LOCATION (City, town, or country) (State) PRINCE GEORGE'S CO. MD.	
23. FUNERAL DIRECTOR DERRITT FUNERAL HOME, INC., WASH. D.C.		ADDRESS		24a. REC'D BY REGISTRAR SEP 18 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MEDICAL CERTIFICATION

(M)

10238

10538

Prince George's
Chancellor

Prince George's General Hospital

Levinson
Freeman

Levinson
Freeman

Levinson
Freeman

Levinson
Freeman

Levinson
Freeman

Levinson
Freeman

Levinson
Freeman

Levinson
Freeman

Levinson
Freeman

Levinson
Freeman

Levinson
Freeman

Levinson
Freeman

Levinson
Freeman

Levinson
Freeman

Levinson
Freeman

Levinson
Freeman

Levinson
Freeman

Levinson
Freeman

Levinson
Freeman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 4503 Burlington Rd., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jessie First Middle Last Gallagher		4. DATE OF DEATH September 11 19 61 Month Day Year	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-8-11 9. AGE (in years last birthday) 50 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk 10b. KIND OF BUSINESS OR INDUSTRY Drug Store		11. BIRTHPLACE (County & State, or foreign country) West Virginia 12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Walter Gorden		14. MOTHER'S MAIDEN NAME Lydia Reynolds	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Lydia Gorden 17. INFORMANT Hyattsville, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 171X DUE TO Ca of cervix Conditions, if any, which gave rise to immediate cause (b) 2 years (c) 2 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 21. I certify that (I) (this hospital) attended the deceased from 10 years to 1961 , that (I) (we) last saw the deceased alive on 9-11-1961 and that death occurred at 5:50 P.M. from the causes and on the date stated above.		INTERVAL BETWEEN ONSET AND DEATH 2 years	
22a. SIGNATURE Dayton O Watkins 22c. PHYSICIAN'S NAME (Type) DAYTON O WATKINS		22b. DATE SIGNED SEP 15 '61 22d. ADDRESS 6318 Annapolis Rd Bladensburg Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 14, 1961	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE A. Gasch's Sons ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR SEP 15 '61 DATE 25b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

10534

(M)

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

Person born 1912

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10541

10535

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5909 Taylor Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> d. STREET ADDRESS <u>5909 Taylor Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Sherman</u>		4. DATE OF DEATH Last <u>Garling House</u> Month <u>Sept.</u> Day <u>25</u> Year <u>1961</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25, 1872</u>	9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Brainerd, Minn.</u>			
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT (Print name) <u>Mrs. Dorothy M. Frank</u> Address <u>5909 Taylor Rd. Riverdale, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> (b) <u>arteriosclerotic Heart Disease</u> (c) <u>Gangrene of leg with amputation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u>	(County) <u> </u>	(State) <u> </u>		
21. We certify that we (this hospital) attended the deceased from <u>9-3</u> , 19 <u>61</u> , to <u>9-24</u> , 19 <u>61</u> , that (X) we last saw the deceased alive on <u>9-22</u> , 19 <u>61</u> , and that death occurred at <u>12:28</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Ronald E. Krum MD</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u> </u>			
22c. PHYSICIAN'S NAME (Type) <u>Ronald E. Krum</u>		22d. ADDRESS <u>8904 2nd Lanham, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>9/27/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City, town or county) <u>Prince Georges County, Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		25a. REC'D BY REGISTRAR <u> </u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Krum</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

10535

10541



THE S. H. HINES CO. 5700 LEXINGTON AVE. NEW YORK 17, N. Y.
LITHOGRAPHED BY THE S. H. HINES CO. NEW YORK, N. Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10542

10536

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr Geo.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 05 Mitchellville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Madison Manor Nursing Home 5801 42nd Ave		d. STREET ADDRESS 1 Enterprise Road	
3. NAME OF DECEASED (Type or print) First Middle Last Marguerite A. Gauthier		4. DATE OF DEATH Sept. 4 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 26, 1885
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) France		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME I Unk. Cotin		14. MOTHER'S MAIDEN NAME Louise Cotin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Patients Record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 025 X DUE TO General paresis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO General arterio sclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 7 mos 5 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1, 1961, to Sept 4, 1961, that (I) (we) last saw the deceased alive on Sept 1, 1961, and that death occurred at 5:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE L W Malin M.D.		22b. DATE SIGNED 9-4-61	
22c. PHYSICIAN'S NAME (Type) L W Malin M.D.		22d. ADDRESS Riverdale Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/7/61	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City, town or county) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR SEP 8 '61	
ADDRESS Hyattsville, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

10542

10542

James Jones A. Transfer

June 25, 1883

James

John Thomas

Thomas

James

James

James

James

[Handwritten signature]

[Handwritten signature]

[Handwritten signature]

[Handwritten signature]

St. Lincoln

St. Lincoln

Hannover, Maryland

St. Lincoln

CERTIFICATE OF DEATH

Reg. Dist. No. 10537

10543

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College PARK</u>				c. LENGTH OF STAY IN 1b <u>10 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9701 NARRAGANSETT PKwy</u>				d. STREET ADDRESS <u>19701 NARRAGANSETT PKwy</u>			
3. NAME OF DECEASED (Type or print) First <u>Emily</u> Middle <u>Gertrude</u> Last <u>Gleason</u>				4. DATE OF DEATH Month <u>September</u> Day <u>18</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 16, 1915</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Montreal, Canada</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Apperti</u>				14. MOTHER'S MAIDEN NAME <u>Jean Lombardi</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-03-5993</u>		17. INFORMANT <u>Husband: Everett Gleason - Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Advanced Metastatic Cancer</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Breast</u> DUE TO (c) <u>-</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 + yrs.</u> <u>3 1/2 + yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. —				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>	
20f. (City or town) <u>-</u>				20g. (County) <u>-</u>			
20h. (State) <u>-</u>							
21. I certify that I attended the deceased from <u>August, 1961</u> , to <u>Sept. 18, 1961</u> , that I last saw the deceased alive on <u>Sept. 15, 1961</u> , and that death occurred at <u>4:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Fredrick Barr</u> M.D.				ADDRESS (Street, city or town, state) <u>4500 College Ave, College Park, Md.</u>			
PHYSICIAN'S NAME (Type) <u>J. Frederick BARR, M.D.</u>				DATE SIGNED <u>9-18-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/21/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) <u>Silver Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>				ADDRESS <u>mt. Rainier Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 20 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

MEDICAL CERTIFICATION

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10544

10538

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY in 1b 			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hosp.							
3. NAME OF DECEASED (Type or print) Ethel		First Middle Last Graves		4. DATE OF DEATH Month Day Year 9 14 1961		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-30-1876	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) Kentucky	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME John L. Thurmond				14. MOTHER'S MAIDEN NAME Martha ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Lorene Little Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia, Rt. Lung. 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Advanced Arterio-Sclerosis (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 13, 1961 to 14 Sept 1961 , that (I) (we) last saw the deceased alive on 13 Sept 1961 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Thomas M. Hutchins M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 14 Sept 1961	
22c. PHYSICIAN'S NAME (Type) Thomas M Hutchins				22d. ADDRESS Landover, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 18, 1961		23c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery		23d. LOCATION (City, town or county) (State) Macon Missouri	
24 FUNERAL DIRECTOR'S SIGNATURE Baschi's Funeral Home				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE SEP 18 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10538

10544

M

I

1072 Nicholson St.

1072 Nicholson St.

11-30-1970

11-30-1970

Kennedy

Kennedy

Marion

John L. Thompson

See Lorenz Little

Handwritten notes:
Brown & Co. 1072 Nicholson St.
Marion 11-30-1970

1072 Nicholson St.

1072 Nicholson St.

1072 Nicholson St.

1072 Nicholson St.

1072 Nicholson St.

1072 Nicholson St.

1072 Nicholson St.

1072 Nicholson St.

1072 Nicholson St.

1072 Nicholson St.

1072 Nicholson St.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10545

CERTIFICATE OF DEATH

11740

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md</u> b. COUNTY <u>Pr. George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>708 Washington Blvd</u>				d. STREET ADDRESS <u>708 Wash Blvd</u>			
3. NAME OF DECEASED (Type or print) <u>Virginia Maude Griffith</u>				4. DATE OF DEATH Month <u>September</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7, 1889</u>	9. AGE (If years last birthday) <u>72 yrs.</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Mishawaka Indiana</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William A. Krieg</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Baugois</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Mrs Grace F. Filling</u> Address <u>1005 Plaza St Clearwater Fla.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Osteogenic Sarcoma Left Femur</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>May 1961</u> to <u>Feb 30, 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 30, 1961</u> , and that death occurred <u>9:00</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert C. Wingfield</u>				22b. DATE SIGNED <u>Feb 30, 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>ROBERT C. WINGFIELD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Connelley</u> ADDRESS <u>Lanham Md</u>				25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>			
DATE <u>OCT 9 '61</u>				25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10546 *inf. from Birth certificate*

11741

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

1. PLACE OF DEATH e. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in 1b 18 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg d. STREET ADDRESS 4913 Monroe Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby Girl		First Baby Girl		Last Habas		4. DATE OF DEATH Month September Day 21 Year 1961	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-21-61	
9. AGE (In years last birthday) 18		IF UNDER 1 YEAR Months 21		IF UNDER 24 HRS. Hours 18 Min. 21		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Franklin D. Habas				14. MOTHER'S MAIDEN NAME Mary Louise Lusby			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give number or date of service)		17. INFORMANT Mother		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atalactin 7625 DUE TO Prenatal fault not 1-b-69 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) 18 hr. (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 21, 1961 to Sept 21, 1961 , that (I) (we) last saw the deceased alive on Sept 21, 1961 , and that death occurred at 10 P.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Robert S. McConney</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Robert S. McConney				22d. ADDRESS 402 Main Street, Laurel, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 10-6-61		23c. NAME OF CEMETERY OR CREMATORY Prince Geo.Gen. Hospital		23d. LOCATION (City, town or county) (State) Cheverly, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Harry W. Penn, Jr.</i> ADDRESS Harry W. Penn, Jr. Administrator				25a. REC'D BY REGISTRAR DATE OCT 9 '61		25b. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i>	

MEDICAL CERTIFICATION



THE JOHN B. STONE, JR.,

BRIDGE AND ROAD, BOSTON, MASSACHUSETTS

W.C. 9

W.C. 9

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
SM 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH e. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brentwood		d. STREET ADDRESS 4006 Utah Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Cheryl Ann Hammond				4. DATE OF DEATH Month September Day 23 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3, 1961	
9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months 2 Days 20		IF UNDER 24 HRS. Hours 2 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Wados Hammond				14. MOTHER'S MAIDEN NAME Ann Marie Kaske			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT James Wados Hammond, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd		22b. DATE THEREOF 9/25/61		22c. NAME OF CEMETERY OR CREMATORY Wash. Natl.		22d. LOCATION (City, town, or country) (State) Leitland Md.	
EXAMINER'S NAME (Type) James I. Boyd		23. FUNERAL DIRECTOR W.W. Chambers Co.		24a. REC'D BY REGISTRAR SEP 26 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

9 V V V V V V V X V V

111

10347

10338

Prince George's
Cheverly
D.O.B.
Maryland
Prince George's

Prince George's General Hospital 4008 Van Avenue

Cheryl Ann
Hammond
September 30, 1961

Female White
July 3, 1961

None
None
Director of Columbia U.S.A.

James Weiss
Ann Marie Harris

None
James Weiss Hammond, name as

neumonia

James I. Boyd

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 10548 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10540

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Comodory Hills</u> c. LENGTH OF STAY in 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>412 Comodory Hills Lane</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Comodory Hills</u> d. STREET ADDRESS <u>412 Comodory Hills Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>George Edward Harper</u>		4. DATE OF DEATH <u>Sept 1 1961</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct 23, 1878</u>		9. AGE (In years, last birthday) <u>82</u> IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>				11. BIRTHPLACE (State or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>George Washington Harper</u> 14. MOTHER'S MAIDEN NAME <u>Willie Louie Harman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Mrs. Daisy Birch, same as #2</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO (b) <u>Cardiovascular renal disease</u> (c) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>James I Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>9-1-61</u>			
EXAMINER'S NAME (Type) <u>JAMES I BOYD</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) <u>412 Comodory Hills Lane</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>RE-BURIAL</u>		22b. DATE THEREOF <u>2 SEP 61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>RIVERVIEW CEMETERY</u>		22d. LOCATION (City, town, or country) <u>RICHMOND</u>		(State) <u>VIRGINIA</u>		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <u>SEP 5 '61</u> <u>Arthur S. Harman</u>	
23. FUNERAL DIRECTOR <u>ROBERT J. MURPHY FUNERAL HOME 3524 COLUMBIA PIKE ARLINGTON, VIRGINIA</u>											

MEDICAL CERTIFICATION

10510

10510

10510
10510
10510

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10549					10541						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY Prince Georges MARYLAND					a. STATE Maryland b. COUNTY Prince Georges						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN lb 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital					d. STREET ADDRESS 2510 Virginia Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Florence V Hartley					4. DATE OF DEATH Month Day Year Sept. 30 19 61						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 Oct. 1912		9. AGE (In years last birthday) 48 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A				
13. FATHER'S NAME unknown					14. MOTHER'S MAIDEN NAME unknown						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-24-3285		17. INFORMANT Oscar Hartley Landover, Md -							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulm. edema 443X DUE TO Hypertensive disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO C.V.A. (c)										9/29/61	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 9/18, 1961, to 9-30, 1961, that (I) (we) last saw the deceased alive on 9-30, 1961, and that death occurred 12,30AM from the causes and on the date stated above.											
22a. SIGNATURE George Hageage					22b. DATE SIGNED 9/30/61		22c. PHYSICIAN'S NAME (Type) Dr. G. Hageage., M.D.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF Oct 3-1961		23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery		23d. LOCATION (City, town or county) Colmar Manor, Md		
24. FUNERAL DIRECTOR'S SIGNATURE F. Saseki					25a. REC'D BY REGISTRAR DATE OCT 2 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

10541

10543

(M)

(1)

378-21-3485

Col. J. P. ...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G256 9/26/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 10543

10550

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna/ b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. LENGTH OF STAY IN TB 4 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FERRARA NURSING HOME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 6616111111 Dresher	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 33 Jeffrey Drive	
3. NAME OF DECEASED (Type or print) HASTINGS EILEEN THERESA		4. DATE OF DEATH SEPT. 16 1961	
5. SEX F		6. COLOR OR RACE N	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 26 Aug 1957	
9. AGE (In years last birthday) 4 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JEREMIAH E. HASTINGS		14. MOTHER'S MAIDEN NAME FRANCES AUDREY SCHULMEYER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT FATHER		Address 33 JEFFREY DR. DRESHERVA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MENINGOMYELOCELE DUE TO 344X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYDROCEPHALUS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SPASTIC TETRAPLEGIA			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/26 , 1957, to 10/16 , 1961, that I last saw the deceased alive on 10/16 , 1961, and that death occurred at 9:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph J. McDonald		ADDRESS (Street, city or town, state) 7309 RIGGS RD DATE SIGNED 9/16/61	
PHYSICIAN'S NAME (Type) JOSEPH J. McDONALD		M.D. HYATTSVILLE, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/18/61	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) BALTIMORE Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. J. Ruck		ADDRESS 5305 HARFORD Rd.	
24a. REC'D BY REGISTRAR SEP 20 '61		24b. REGISTRAR'S SIGNATURE Charles E. Kinn	

CERTIFICATE OF DEATH

1918

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
JAMES J. HENRY		45		M		W		C	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
100 N. BROAD ST. BOSTON		JAN 15 1918		HOME		HEART DISEASE		NATURAL	
OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		TREATMENT	
CLOCK REPAIRER		HIGH SCHOOL		MARRIED		NONE		NONE	
BIRTH		DEATH		BURIAL		INTERMENT		FUNERAL	
JAN 1 1873		JAN 15 1918		CATHOLIC		CATHOLIC		CATHOLIC	
FATHER		MOTHER		SISTER		BROTHER		OTHER	
JAMES J. HENRY		MARY J. HENRY		JOHN J. HENRY		MICHAEL J. HENRY		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF DEPUTY ATTORNEY GENERAL	
J. J. HENRY		J. J. HENRY		J. J. HENRY		J. J. HENRY		J. J. HENRY	
DATE		TIME		PLACE		CAUSE		MANNER	
JAN 15 1918		10:30 AM		HOME		HEART DISEASE		NATURAL	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, MASS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 File G297 10/2/61 mb

CERTIFICATE OF DEATH

Reg. Dist. No. 10554

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4430 FORT DRIVE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PR. GEO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND		c. LENGTH OF STAY IN lb 1 MONTH	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4430 Fort Dr		d. STREET ADDRESS 4430 Fort Drive	
3. NAME OF DECEASED (Type or print) First HOWARD Middle FRANKLIN Last HAYES		4. DATE OF DEATH Month SEPT Day 25 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1893 AUG. 2, 1897
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESSMAN		10b. KIND OF BUSINESS OR INDUSTRY PRINTING	11. BIRTHPLACE (State or foreign country) FORESTVILLE, MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME EDWARD THOMAS HAYES	
14. MOTHER'S MAIDEN NAME BESSIE STRONG		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) 1909-1913	
16. SOCIAL SECURITY NO. NONE		INFORMANT WILHEMINA M. HAYES Address 4430 FORT DRIVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO APOPLEXY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE HEART DISEASE (c) 9 MONTHS			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JAN 15, 1961 to SEPT 25, 1961 that I last saw the deceased alive on SEPT 25, 1961 , and that death occurred at 11 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Vincent J. DiFrancesco		DATE SIGNED 2436 L'ENFANT SQUARE S.E.	
PHYSICIAN'S NAME (Type) VINCENT J. DiFRANCESCO M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-28-61	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.		24a. REC'D BY REGISTRAR SEP 27 61	24b. REGISTRAR'S SIGNATURE Arthur J. Hume

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

(M)



CERTIFICATE OF DEATH

Reg. Dist. No. 10542

10552

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Va.</u> b. COUNTY <u>Alexandria</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale</u>		c. LENGTH OF STAY IN lb <u>6 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>Hicks</u> Last <u>Haynes</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 4, 1902</u>
9. AGE (In years lost birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Albermarle Co. Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL E. HICKS</u>		14. MOTHER'S MAIDEN NAME <u>TEARESSA BRYANT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>227-14-4088</u>	
17. INFORMANT <u>MR Claude L Haynes</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute gastrointestinal hemorrhage</u> 151X DUE TO <u>Carcinomatosis generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Lymphosarcoma of Stomach</u> (c) <u>8 months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>8 months</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>61</u> , to <u>Sept 30</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Sept 30</u> , 19 <u>61</u> , and that death occurred at <u>2:30</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H James Kutz</u>		ADDRESS (Street, city or town, state) <u>R.F.D. Glenn Dale Md</u>	
PHYSICIAN'S NAME (Type) <u>H James Kutz</u>		DATE SIGNED <u>9/30/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/4/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ivy Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Alexandria Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>EVERLY-WHEATLEY FUNERAL HOME ALEXANDRIA, VA</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>OCT 5 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Turner</u>	

10232
Faint, illegible text, possibly a document or form, with some visible markings and a large dark smudge on the right side.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

<p style="font-size: 1.5em; margin: 0;">10553</p> <p>1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND</p>		<p style="font-size: 1.5em; margin: 0;">10545</p> <p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u></p>	
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u></p>		<p>c. LENGTH OF STAY IN 1b <u>66</u></p>	
<p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's General</u></p>		<p>e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u></p>	
<p>d. STREET ADDRESS <u>6700 Patterson Street</u></p>		<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) First <u>Baby Girl</u> Middle <u>Heiss</u> Last <u>Heiss</u></p>		<p>4. DATE OF DEATH Month <u>September</u> Day <u>3</u> Year <u>19 61</u></p>	
<p>5. SEX <u>Female</u></p>	<p>6. COLOR OR RACE <u>White</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>9-2-61</u></p>
<p>9. AGE (In years last birthday) yrs. <u>N.B.</u></p>		<p>IF UNDER 1 YEAR Months <u>9</u> Days <u>21</u> IF UNDER 24 HRS. Hours <u>21</u> Min. <u>21</u></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u></p>	
<p>11. BIRTHPLACE (State or foreign country) <u>Md.</u></p>		<p>12. CITIZEN OF WHAT COUNTRY?</p>	
<p>13. FATHER'S NAME <u>David Clyde Heiss</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Eleanor Catherine Thompson</u></p>	
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u></p>		<p>16. SOCIAL SECURITY NO.</p>	
<p>17. INFORMANT <u>Mother</u></p>		<p>Address <u>as above</u></p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Crematority</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO _____ (c) _____</p>			
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>23 hrs.</u></p>			
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>			
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <u>9/1</u> to <u>9/3</u>, 19<u>61</u>, that (I) (was) last saw the deceased alive on <u>9/3</u> 19<u>61</u>, and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above.</p>			
<p>22a. SIGNATURE <u>[Signature]</u> M.D.</p>		<p>22b. DATE SIGNED <u>9/3</u></p>	
<p>22c. PHYSICIAN'S NAME (Type) <u>F. F. MUSTY, M.D.</u></p>		<p>22d. ADDRESS <u>4410 74th Ave, Landover Hills, Md.</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u></p>		<p>23b. DATE THEREOF <u>9/7/61</u></p>	
<p>23c. NAME OF CEMETERY OR CREMATORY <u>Prince Geo. Gen. Hospital</u></p>		<p>23d. LOCATION (City, town, or county) (State) <u>Cheverly, Maryland</u></p>	
<p>24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u></p>		<p>25a. REC'D BY REGISTRAR <u>DATE SEP 13 '61</u></p>	
<p>25b. REGISTRAR'S SIGNATURE <u>[Signature]</u></p>		<p>25c. REGISTRAR'S SIGNATURE <u>[Signature]</u></p>	

1925

M
C

10-15



10554										10546														
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND										2. USUAL RESIDENCE (Where deceased lived. If institution: Res. of care before admission) a. STATE Md. b. COUNTY Prince Georges														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Brentwood					c. LENGTH OF STAY IN 1b 55 yrs					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Brentwood					d. STREET ADDRESS 4504 41st Ave					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ELLA ELEANOR HOBBS										4. DATE OF DEATH Sept 24 19 61														
5. SEX Female		6. COLOR OF RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr 4 1883				9. AGE (In years lost birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) DC					12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME William Matthews					14. MOTHER'S MAIDEN NAME Elizabeth Webb																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO.					17. INFORMANT Address MRS Gladys Johnson 4504 41st Ave														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Valvular heart disease 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 3 yrs														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Capitis, Senile										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from Sept 14 19 61 to Sept 24 19 61 that (I) (we) last saw the deceased alive on Sept 24 19 61, and that death occurred at 3:30 P. M. from the causes and on the date stated above.										22a. SIGNATURE W.S. Hudson, M.D. ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 9/24/61														
22c. PHYSICIAN'S NAME (Type) W.S. HUDSON					22d. ADDRESS 509 R.I. Ave N.W.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE THEREOF 9/27/61					23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEM. CEMETRY SUITLAND MARYLAND					23d. LOCATION (City, town, or county) (State)									
24. FUNERAL DIRECTOR'S SIGNATURE Robert M. Lewis					25a. REC'D BY REGISTRAR DATE SEP 26 61					25b. REGISTRAR'S SIGNATURE Arthur S. Travis														

10

10254

CENTRAL CASE OF DEATH

10254

From the ...
... ..

ELIA ELIASH ...
... ..

... ..
... ..

... ..
... ..

... ..

... ..
... ..

... ..
... ..

21 hours after death. The law requires that the death certificate be examined by the attending physician and completed in by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined by the attending physician and completed in by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
10555																			
10547																			
1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood c. LENGTH OF STAY IN b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 46 Brentwood d. STREET ADDRESS 3600 Webster st, Brentwood e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>														
3. NAME OF DECEASED (Type or print) John Paul Hoffman, Sr					4. DATE OF DEATH Month Sept Day 17 Year 1961														
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/15/1873		9. AGE (in years last birthday) 88 yrs.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) D. C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.												
13. FATHER'S NAME Wm. J. Hoffman					14. MOTHER'S MAIDEN NAME Agnes B. Sheehan														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO. 577-14-7978					17. INFORMANT Mrs Ruth C. Hoffman Address 3600 Webster St,									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate with metastasis 177X DUE TO (b) metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) 17 Sept 61					20g. (County) 17 Sept 61					20h. (State) 17 Sept 61									
21. I certify that (I) (this hospital) attended the deceased from 17 Sept 61 to 17 Sept 61 , that (I) (u) last saw the deceased alive on 17 Sept 61 , and that death occurred at 5 M, from the causes and on the date stated above.																			
22a. SIGNATURE A.W. Mc Laurin					22b. DATE 17 Sept 61					22c. PHYSICIAN'S NAME (Type) A.W. Mc LAURIN, MD.									
22d. ADDRESS 4637 EASTERN Ave					22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22f. ADDRESS 4637 EASTERN Ave									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 9/21/61					23c. NAME OF CEMETERY OR CREMATORY Arlington									
23d. LOCATION (City, town or county) Ft Myer					23e. (State) Va					23f. REC'D BY REGISTRAR SEP 20 '61									
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home					24a. ADDRESS 300 4th NE Wash. D. C					24b. REGISTRAR'S SIGNATURE Arthur S. Kraus									

M

10533

10547

Prince George

Prince George

Prince George

Brantwood

Brantwood

2000 Webster St. Brantwood

John

Paul

Boltman, Sr

88

6/15/1873

Male

White

Resided

D. C.

U.S.A.

Mr. J. Holtman

James H. Holtman

27-14-7078 Mrs John J. Holtman 2000 Webster St.

See also of parent's

*Mr. J. Holtman
4429 Eastern Ave
St. Louis, Mo*

Resided

St. Louis

St. Louis

St. Louis

See funeral home 300 Lenox Wash. D. C. SEP 10 1914

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18, Form Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10556 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 9 Film G295 9/21/61 iwk											
10548											
1. PLACE OF DEATH a. COUNTY Prince George's						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly						c. LENGTH OF STAY IN 1b D.O.A.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 37 Landover Hills					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						d. STREET ADDRESS 4110 72nd Avenue					
3. NAME OF DECEASED (Type or print) John Howard			First Middle Last Holland Sr			4. DATE OF DEATH Month Day Year September 18 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct, 26, 1913		9. AGE (In years last birthday) yrs. 47 48		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY RCA				11. BIRTHPLACE (State or foreign country) Virginia			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Samuel Howard Holland				14. MOTHER'S MAIDEN NAME Mary Reamy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 1933-39				17. INFORMANT Address Estelle Bryan Holland, same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) James I. Boyd						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DATE SIGNED 9/18/61					
						Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 22 Sept. 1961		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		22d. LOCATION (City, town, or country) Bladensburg,		(State) Md.	
23. FUNERAL DIRECTOR Lee Funeral Home 300-4th St. N.E.D.C.						ADDRESS Wash.		24a. REC'D BY REGISTRAR DATE SEP 20 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

(M)

Prince George's

Overly

U.S.A.

Londoner Hall

Prince George's General Hospital

1110 13th Avenue

John Howard

Holland 2

September 18 41

Male

White

Oct, 28, 1912

English

BOA

Virginia

USA

Samuel Howard Holland

W-ry Booby

Yes 19-2-22

Seattle Ryan Holland, same as S

Colonel's Decoration

Colonel's Army Medal

James I. Boyd

2/20/41

10557

CERTIFICATE OF DEATH

Reg. Dist. No. 10549

1. PLACE OF DEATH o. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Ps Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>				c. LENGTH OF STAY IN 1b <i>2 1/2 yrs</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Switland Nursing Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Dora</i> Middle <i>L</i> Last <i>Jenkins</i>				4. DATE OF DEATH Month <i>Sept</i> Day <i>28</i> Year <i>1961</i>			
5. SEX <i>Fem</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JAN. 17. 1873</i>	9. AGE (In years, months, days) <i>88 yrs.</i>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Wiet Lippold</i>				14. MOTHER'S MAIDEN NAME <i>MARGARET WILLIAMS</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>R.L. Jenkins Jr. Switland</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute congestive cardiac failure</i> 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardiovascular</i> DUE TO <i>Renal Disease - Sickle</i> (c) <i>unknown</i>							INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <i>none of note</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Natural Causes</i>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>— 19</i>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <i>Jan 1</i> 19 <i>59</i> , to <i>Sept 28</i> 19 <i>61</i> , that I last saw the deceased alive on <i>Sept 27</i> 19 <i>61</i> , and that death occurred at <i>740</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Paul C Van Natta</i>		ADDRESS (Street, city or town, state) <i>5440 Silver Hill Rd SE Washington 28 DC</i>					
PHYSICIAN'S NAME (Type) <i>PAUL C VAN NATTA</i>		DATE <i>Washing 28 DC</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIED</i>	22b. DATE THEREOF <i>9-30-1961</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Switland Maryland</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. W. Lee</i>		ADDRESS <i>Wash. D.C.</i>		24a. REC'D BY REGISTRAR <i>DATE OCT 2 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kline</i>		

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10227

(M)

(1)

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10550

10558

Item 7 Film G297 10/13/61 iwk

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 5 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aquasco d. STREET ADDRESS Eagle Harbor, RFD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Caroline First Jones Middle Female Sex Colored Color or Race		4. DATE OF DEATH September 25 Month 1961 Day 77 Yrs. IF UNDER 1 YEAR Months Days Hours Min.	
5. SEX Female		6. COLOR OR RACE Colored	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-6-84	
9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10a.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME Rowell Norfolk		14. MOTHER'S MAIDEN NAME Cordelia Earl	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) 15a.		16. SOCIAL SECURITY NO. 16.	
17. INFORMANT Joseph Jones--Eagle Harbor, Maryland Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pul. edema DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Hb. disease DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sep 25 1961 to Sep 25 1961 , that (I) (we) last saw the deceased alive on Sep 25 1961 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. Samuel J. N. Sugar		22b. DATE SIGNED SEP 25 1961	
22c. PHYSICIAN'S NAME (Type or print) Dr. Samuel J. N. Sugar		22d. ADDRESS 4637 Eastern Ave., Washington 18, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/30/61	
23c. NAME OF CEMETERY OR CREMATORY St. Edmonds Methodist Church		23d. LOCATION (City, town or county) (State) Calvert County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John F. Stewart Jr.		25a. REC'D BY REGISTRAR SEP 29 1961	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		25c. DATE SEP 29 1961	

VR A15 4
15M 9/60

10552

(M)

James M. ...

...

...

...

...

(7)

...

...

...

...

...

...

...

...

...

...

...

...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 10551

10559

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Aquasco</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Aquasco</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>FLORENCE YOUNG JONES</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21, 1901</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Aquasco Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>JOSEPH H. YOUNG</u>	
14. MOTHER'S MAIDEN NAME <u>MARGARET GIBBONS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>217-36-5832</u>		17. INFORMANT <u>Arthur Jones - Aquasco Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Myocardial Failure</u> 199X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular Collapse</u> DUE TO (c) <u>Carcinomatous</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 week</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 13</u> 19 <u>60</u> to <u>Sept 18</u> 19 <u>61</u> , that I last saw the deceased alive on <u>Sept 18</u> 19 <u>61</u> , and that death occurred at <u>7:35 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jahel M. Seron</u> M.D.		ADDRESS (Street, city or town, state) <u>Aquasco Md</u>	
PHYSICIAN'S NAME (Type) <u>VANEH M. SERON MD</u>		DATE SIGNED <u>9/18/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9-20-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST MARYS</u>	22d. LOCATION (City, town, or county) (State) <u>AQUASCO, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The HUNTT Funeral Home, WILDORE, MD.</u>		24a. REC'D BY REGISTRAR <u>SEP 26 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10560

10552

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover d. STREET ADDRESS Rt. 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Julia Middle Z. Last Jones		4. DATE OF DEATH Month Sept. Day 15 Year 1961		9. AGE (In years last birthday) 47 yrs. IF UNDER 1 YEAR Months Days Hours Min.			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania			
13. FATHER'S NAME Lawrence Zabinski		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Thomas C Jones Address Landover, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 331X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Cerebral haem.				INTERVAL BETWEEN ONSET AND DEATH 300s			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20f. (City or town) Landover (County) (State)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
21. I certify that (I) (this hospital) attended the deceased from 9-5, 1961, to 9-15, 1961, that (I) (we) last saw the deceased alive on 9-15, 1961, and that death occurred at 4 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Leonard Hays Dr. Leonard Hays		22b. DATE SIGNED 9-15-61		22c. ADDRESS 5201 Baltimore Avenue Hyattsville Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 19, 1961		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery			
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR SEP 21 '61			
				25b. REGISTRAR'S SIGNATURE Arthur L. Hays			

M

272

[Faint handwritten notes at the bottom of the page]

12-1-10

11-21-80

1000-1000-1000

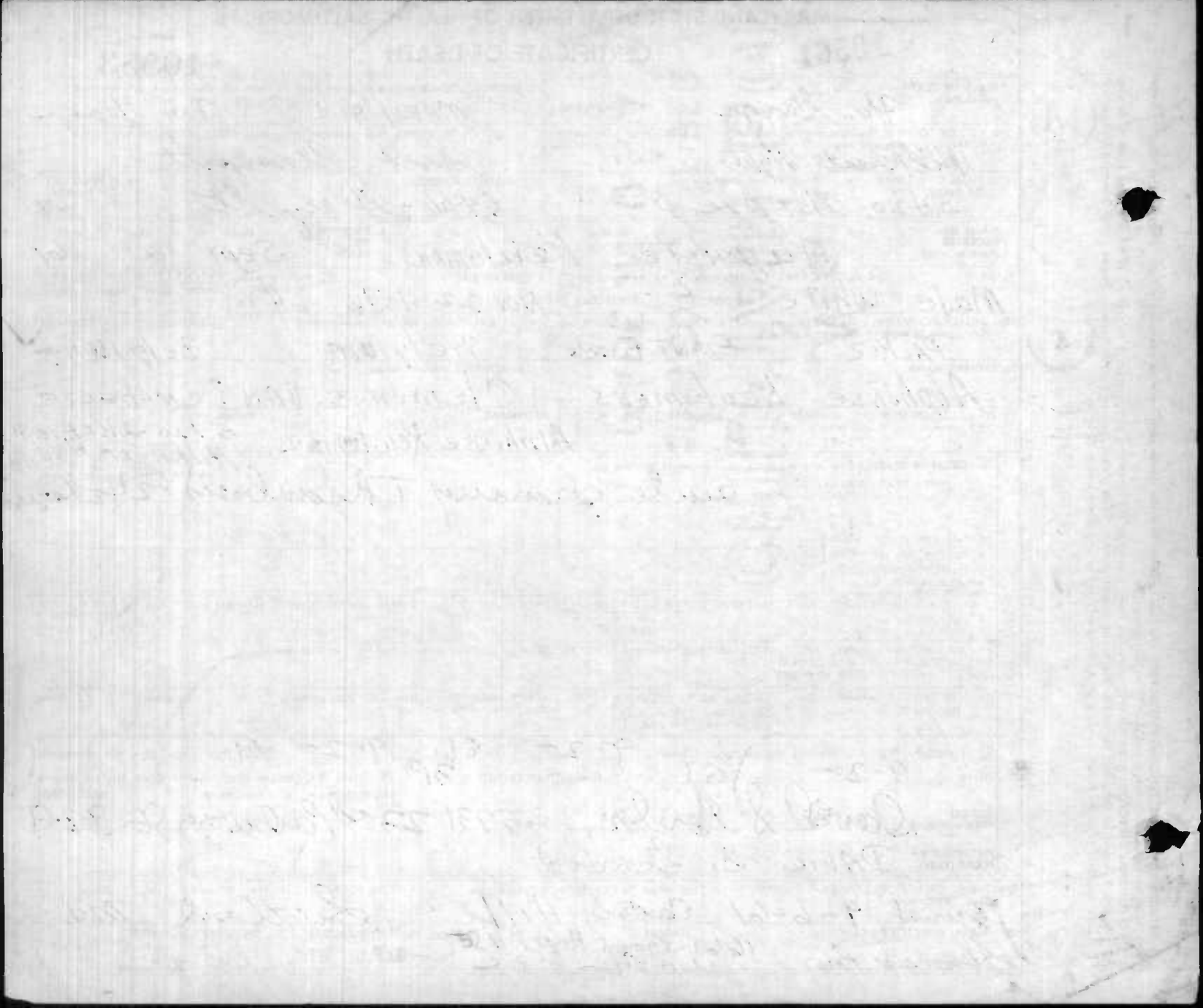
CERTIFICATE OF DEATH

Reg. Dist. No. 10553

1. PLACE OF DEATH a. COUNTY <i>Pr. George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MARYLAND</i> b. COUNTY <i>Pr. George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hickrest Hgts</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>29 Seat Pleasant</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3420-21st Ave SE</i>		d. STREET ADDRESS <i>6406- Greig St</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Auguste Kewlemans</i>		4. DATE OF DEATH Month Day Year <i>Sept 2 1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 22 1896</i>
9. AGE (In years lost birthday) <i>64</i> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Packer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Giant Foods</i>	
11. BIRTHPLACE (State or foreign country) <i>Belgium</i>		12. CITIZEN OF WHAT COUNTRY? <i>Belgium</i>	
13. FATHER'S NAME <i>Alphonse Kewlemans</i>		14. MOTHER'S MAIDEN NAME <i>Clemence VAN Denabeele</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Alphonse Kewlemans</i>	
17. INFORMANT Address <i>5420-21st Ave SE Hickrest Hgts Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute coronary thrombosis</i> 4-20-11 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>2 1/2 hours</i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9-2-</i> , 19 <i>61</i> , to <i>9-2-</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>9-2-</i> , 19 <i>61</i> , and that death occurred at <i>3P.</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>David S. Gordon</i> ADDRESS (Street, city or town, state) <i>5731 23rd Parkway SE</i> DATE SIGNED <i>9-2-61</i> PHYSICIAN'S NAME (Type) <i>DAVID S. GORDON</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-6-61</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Southland Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Shermans Bros</i> ADDRESS <i>1661- Good Hope Rd SE Wash 20 DC</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 5 '61</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4 1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4 1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10562

10554

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY in 1b 3 Weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 6216 42nd Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Harry C. Koehler				4. DATE OF DEATH Month Day Year 9 19 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-8-88	
9. AGE (In years last birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator-Instructor Navy Yard		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard Koehler				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No - - - - -				16. SOCIAL SECURITY NO. 578-38-6792		17. INFORMANT Hosp. records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Cardiac arrest DUE TO (b) Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Sept 6, 1961 to Sept 19, 1961, that (I) (we) last saw the deceased alive on Sept 19, 1961, and that death occurred at 11 A.M. from the causes and on the date stated above. 22a. SIGNATURE Ronald E. Krum M.D. 22b. DATE SIGNED Sept 19, 1961 22c. PHYSICIAN'S NAME (Type) Krum, Ronald E. 22d. ADDRESS 4404 Queensbury Rd. Riverdale, Md. 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 23b. DATE THEREOF 9-22-61 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln 23d. LOCATION (City, town or county) (State) Bladensburg, Md. 24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Riverdale, Md. 25a. REC'D BY REGISTRAR DATE SEP 21 '61 25b. REGISTRAR'S SIGNATURE C. L. H. H. H.							

10574

10568

(M)

(1)

Operator - Inspector Navy Yard
Howard Kasky
578-36-6732
New York
1-1-88
73
X

U.S. Ordnance Co. Riverdale, Md.
2-22-17 Ft. Lincoln
Bladenburg, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item 1 Film G302 12/18/61 10555											
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly Md. A.A.F. Base c. LENGTH OF STAY IN lb D.O.A.						2. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) East Riverdale, Md.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Andrews Air Force Base Hosp. Prince Georges General Hospital						d. STREET ADDRESS 6708 Hamilton Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Raymond B. Lambert						4. DATE OF DEATH Sep. 3, 1961					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 25, 1944		9. AGE (In years last birthday) 17 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY school				11. BIRTHPLACE (County & State, or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Raymond M Lambert						14. MOTHER'S MAIDEN NAME Sara Burgess					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No x				16. SOCIAL SECURITY NO. none		17. INFORMANT Raymond M. Lambert Address East Riverdale, Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia - 824X DUE TO Aspiration (intrapulmonary) of blood. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Multiple blunt-force injuries to head & upper respiratory tract hemorrhage. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient thrown out of car							
20c. TIME OF INJURY Month, Day, Year Hour 6:30 a.m. 9/3/61 19 61				20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not White <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office bldg, etc.) W.P. Ave & Suitland Hwy.		20f. (City or town) P. Georges Co. (County) Md. (State)			
21. I certify that (I) (this hospital) attended the deceased from 2:30 AM (9/3, 1961) to 2:30 (9/3, 1961) that (I) (we) last saw the deceased alive on 9/3/61 19 61 , and that death occurred at 2:30 AM , from the causes and on the date stated above.											
22a. SIGNATURE Howard N. Stewart M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/3/61			
22c. PHYSICIAN'S NAME (Type) Howard N. STEWART						22d. ADDRESS Andrews Air Force Base Hosp., Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Sept 6, 1961		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City, town or county) Colmar Manor, Md. (State)			
24 FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.						25a. REC'D BY REGISTRAR SEP 7 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

(M)

10553

10555

Prince George's

Barryland

Prince George's

Cherry Hill

D.O.A.

East Riverdale, Md.

Prince Georges General Hospital

10708 Hamilton Street

Raymond

Lawrence

July

July

1941

1941

1941

1941

May 22, 1941

17

Student

School

Washington, D. C.

D. C.

D. C.

Raymond E. Lambert

Saint Martins

name

Raymond E. Lambert

East Riverdale, Md.

[Faint, mostly illegible handwritten notes and signatures covering the lower half of the page.]

CERTIFICATE OF DEATH

Reg. Dist. No.

10564

10566

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERWYN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERWYN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8720 63rd AVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First DELA Middle CY Last LAYTON		4. DATE OF DEATH		Month SEPT Day 1 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 14, 1895	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIRE FIGHTER		10b. KIND OF BUSINESS OR INDUSTRY ST. ELIZ. HOSPITAL, D.C.		11. BIRTHPLACE (State or foreign country) Broom Co. NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JOHN LAYTON				14. MOTHER'S MAIDEN NAME ROSIE GATES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-28-6131		17. INFORMANT DAISY M. LAYTON Address SAME AS #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rectum 154X DUE TO with General metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	Month 19	Day 19	Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-23-61 , 19 61 , to 8-29 , 19 61 , that I last saw the deceased alive on 8-29 , 19 61 , and that death occurred at 9:38 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Riverdale, Md DATE SIGNED 9-1-61							
ACTUAL SIGNATURE LW Malin M.D.				PHYSICIAN'S NAME (Type) LW Malin M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-5-1961	22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	22d. LOCATION (City, town, or county) (State) SUITLAND, MARYLAND				
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Riverdale, Maryland				24a. REC'D BY REGISTRAR SEP 6 '61		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10364

(M)

1. NAME OF DECEASED <i>John A. Taylor</i>		2. SEX <i>Male</i>	
3. AGE <i>43</i>		4. DATE OF BIRTH <i>1891</i>	
5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>None</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>1915</i>	
9. NAME OF SPOUSE <i>Elizabeth Taylor</i>		10. DATE OF DEATH <i>1934</i>	
11. PLACE OF DEATH <i>Home</i>		12. CAUSE OF DEATH <i>Heart Disease</i>	
13. MEDICAL HISTORY <i>None</i>		14. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
15. SIGNATURE OF DECEASED <i>[Signature]</i>		16. SIGNATURE OF WITNESS <i>[Signature]</i>	
17. SIGNATURE OF REGISTRAR <i>[Signature]</i>		18. SIGNATURE OF CLERK <i>[Signature]</i>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10565

CERTIFICATE OF DEATH

10557

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY in b. 2 yrs., 2 mos., & 4 days		d. STREET ADDRESS 617 H. St., N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sic Foon Lee		4. DATE OF DEATH Month Day Year 9 14 19 61	
5. SEX Male		6. COLOR OR RACE (Chinese) white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/15/02	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min. - - - -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry worker		10b. KIND OF BUSINESS OR INDUSTRY Owner of Laundry	
11. BIRTHPLACE (County & State, or foreign country) China		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lee Him Kong		14. MOTHER'S MAIDEN NAME Chin See	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No -		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the liver, probably metastatic, primary unknown. DUE TO (b) - DUE TO (c) - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Pulmonary tuberculosis, far advanced, active (20 years); internal hemorrhoids resected 8/14/61; addiction to heroin (historical)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/10/1961 to 9/14/1961, that (I) (we) last saw the deceased alive on 9/14/1961, and that death occurred at P.M., from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 9/14/61	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-19-61	
23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Cem.		23d. LOCATION (City, town or county) (State) Hyattsville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. M. Lee & Sons		25a. REC'D BY REGISTRAR DATE SEP 19 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1955

1955

(M)

(I)

Mr. [illegible]

Los Angeles, Calif.

1955-1-14

1955-1-14

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10566 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if instituting before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly						c. LENGTH OF STAY IN IL D.O.A.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Charles Raymond Little						4. DATE OF DEATH September 19 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 14, 1906		9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Emanuel Odis Little						14. MOTHER'S MAIDEN NAME Harriette Parks					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes						16. SOCIAL SECURITY NO. WW 11		17. INFORMANT 4134 40th Street Mrs Frances Lentz, North Arlington, Va			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO 442X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 9/20/61 DATE SIGNED Address (Street, city, town, or county)											
ACTUAL SIGNATURE James I. Boyd				EXAMINER'S NAME (Type) James I. Boyd							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/23/61		22c. NAME OF CEMETERY OR XXXXXX St. John's Church		22d. LOCATION (City, town, or county) (State) Beltsville, Md.			
23. FUNERAL DIRECTOR Francis Gasch's Sons						ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR SEP 21 '61		24b. REGISTRAR'S SIGNATURE Charles E. Hume	

M

1

RECEIVED

1944

1944

M

10553

10553

Robertson
Robertson

John P. [unclear]

X

Baltimore

Evergreen

9151

Port

Hyattsville, Maryland

F. Casch's Sons

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10568

10560

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Massachusetts</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN <u>3 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Braintree</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Manor</u>				d. STREET ADDRESS <u>58x-3</u>			
3. NAME OF DECEASED (Type or print) <u>Winifred S. Loftus</u>				4. DATE OF DEATH <u>Sept. 6</u> 19 <u>61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 30, 1875</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret'd Post Mistress</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Conn.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>							
13. FATHER'S NAME <u>Patrick O'Sullivan</u>				14. MOTHER'S MAIDEN NAME <u>Winifred Seery</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Miss Mary W. Sullivan</u> Address <u>4801 Conn. Ave. N.W., Wash. DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarct</u> (c) <u>Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>60</u> to <u>Sept</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>June 30</u> , 19 <u>61</u> , and that death occurred at <u>7A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard P. Delaney</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD P. DELANEY MD.</u>				22d. ADDRESS <u>4323 Harvard St. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-9-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Warren, Mass.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Collins</u> ADDRESS <u>3821-14th St. N.W. Wash DC</u>				25a. REC'D BY REGISTRAR <u>SEP 8 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knap</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10560

10560

M

I

Handwritten signature

Handwritten signature

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10569

10561

1. PLACE OF DEATH e. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs c. LENGTH OF STAY IN 1b 21 hrs 10 min d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ANDREWS AIR FORCE HOSP, MD.		2. USUAL RESIDENCE (Where deceased lived, in this city, or residence before admission) e. STATE MD. b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highland Park d. STREET ADDRESS 1205 70th Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (J. MADISON) COLETTE MADISON		4. DATE OF DEATH Month SEPT Day 4 Year 1961	
5. SEX Female	6. COLOR OR RACE Negroid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 SEPT. '61
9. AGE (In years, last birthday) 21		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months 21 Days 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Prince Georges, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William J. Madison		14. MOTHER'S MAIDEN NAME SHIRLEY PROCTOR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMATION Hospital Chart		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 762.5 DUE TO Condillons, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary Atelectasis lung (c) PREMATURITY.		INTERVAL BETWEEN ONSET AND DEATH 21 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from 3 Sept , 19 61 , to 4 Sept , 19 61 , that the (we) last saw the deceased alive on 4 Sept , 19 61 , and that death occurred at 2:19 p.m., from the causes and on the date stated above.			
22a. SIGNATURE Nicholas P. Haritos M.D.		22b. DATE SIGNED 4 Sept 61	
22c. PHYSICIAN'S NAME (Type) NICHOLAS P. HARITOS, CAPT		22d. ADDRESS USAF HOSPITAL ANDREWS, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-7-61	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City, town or county) (State) Arlington Va.
24. FUNERAL DIRECTOR'S SIGNATURE Butt Taylor		25a. REC'D BY REGISTRAR SEP 7 '61	
ADDRESS 909 6th St, N.W.		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

2050203XVI

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

20501

M

✓ 15.20 71340-324

...В ПОСЛЕДНЕМ.

Ізносний розрахунок

10-7-9

14120

W. 1,33 152 909

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, list name and address) e. STATE Pennsylvania b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norristown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 1750 Powell Street	
3. NAME OF DECEASED (Type or print) First Angeline Middle Manderacchi Last September 8, 1961		4. DATE OF DEATH Month September Day 8 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1917
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Garment Mfg.	
11. BIRTHPLACE (State or foreign country) Norristown, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Venezia		14. MOTHER'S MAIDEN NAME Maria Tulone	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Vincent Venezia		Address Chalfont, Penna.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) Crushed chest, fracture of the skull (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Head on collision with another automobile	
20c. TIME OF INJURY Month, Day, Year 12:48xx 9/8/ 61		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 301	
20e. INJURY OCCURRED While <input checked="" type="checkbox"/> at work or Not While <input type="checkbox"/> at work		20f. CITY OR TOWN (State) Upper Marlboro P.G. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED Sept. 8, 1961	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. DATE THEREOF 9-12-1961		22c. NAME OF CEMETERY OR CREMATORY St. Patrick's	
22d. LOCATION (City, town, or country) Norristown, Penna.		22e. ADDRESS (Street, city, town, or county) W. W. Chambers, 5801 Cleveland Ave.	
23. FUNERAL DIRECTOR W. W. Chambers, 5801 Cleveland Ave.		24a. REC'D BY REGISTRAR SEP 13 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

W. E. Chambers, 5801 Cleveland Ave.,
Livonia, Mich.

7-12-1931 St. Patrick's
Church, Livonia, Mich.

JAMES I. SOYD, M.D.

Sept. 3, 1931

He died on collision with motor automobile

12:30 a.m. 9/3/31 at Route 301
Upper Merion, Pa.

X X

X

Crushed chest, fracture of the skull

Hemorrhage and shock

W/o Vincent Veneria, Canton, Penn.

Joseph Veneria, Maria Tullene

Machine Operator, German Mfg. Corporation, Penn. U. S. A.

Female, White

April 13, 1917 44

Appoline, Madagascar

September 3, 1931

Prince George's General Hospital 1750 Hospital Street

Overbury

Northtown

Prince George's

Johns Hopkins

Monterey

1933

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18, Form Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10571 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10563											
1. PLACE OF DEATH a. COUNTY <u>Pr George</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Hill</u> c. LENGTH OF STAY in 1b <u>DoA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pr George General Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cedar Heights 30</u> d. STREET ADDRESS <u>6403 Lee Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>George Robert</u> First Middle Last						4. DATE OF DEATH <u>MANNS</u> Month Day Year <u>9 - 15 1961</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 14, 1888</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gert.</u>				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Manns</u>						14. MOTHER'S MAIDEN NAME <u>Adeline Queen</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)						16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Florence Baker Triangle</u> Address <u>Box 146, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary Edema</u> <u>420.0</u> DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Arterio Sclerotic Heart disease</u> (b) <u>4 mo</u> (c) <u>4 mo</u> INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Dayton O Watten</u> EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>9-16-61</u> Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>9-20-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smith Hill</u>		22d. LOCATION (City, town, or country) (State) <u>Quantico, Va</u>			
23. FUNERAL DIRECTOR <u>Myrtle K Rollins</u> Address <u>4339 Hunt Pl. N.E., Wash. D.C.</u>						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krump</u>			
DATE <u>SEP 20 '61</u>											

10583

10583

(M)

(1)

Florence Baker Triangle

10583

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10572

10564

1. PLACE OF DEATH e. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MD b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College PK.	
c. LENGTH OF STAY IN 1b 30 min		d. STREET ADDRESS 9026 49TH PL.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANCIS L MARLOW		4. DATE OF DEATH Month Day Year sept 30, 1961	
5. SEX MALE		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 21, 1909	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repair man		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George N. Marlow		14. MOTHER'S MAIDEN NAME Katherine Ellen Hammond	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. Lydia H. Marlow Same as # 2 Wife	
17. INFORMANT Lydia H. Marlow Same as # 2 Wife		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic Stenosis DUE TO (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 2 hrs 2 yrs 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hereditary Cerebellar Ataxia		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1956 to 9/30 , 19 61 that (I) (we) last saw the deceased alive on 9/30 , 19 61 and that death occurred at 3:40 AM , from the causes and on the date stated above.			
22a. SIGNATURE Norman Donat Comen M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 9/30/61	
22c. PHYSICIAN'S NAME (Type) Norman Donat Comen		22d. ADDRESS 3503 Penny St Mt Rainier Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) XXXXX Burial		23b. DATE THEREOF 10/2/61	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City, town or county) (State) Colmar Manor. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland	
25a. REC'D BY REGISTRAR DATE OCT 2 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

I

MEDICAL CERTIFICATION

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10573

10565

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> c. LENGTH OF STAY IN 1b <u>life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6309 - Murkirk Rd.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> d. STREET ADDRESS <u>6309 - Murkirk Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>BERTIE</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6, 1883</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u> </u>	
13. FATHER'S NAME <u>Henson Warner</u>		14. MOTHER'S MAIDEN NAME <u>Griscilla Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Samuel Marshall</u>		Address <u>6311 - Murkirk Rd. Beltsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A.S.C.V.R. Disease</u> <u>442</u> DUE TO (b) <u>Gen. Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>20 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>6/1</u> <u>1938</u> to <u>9/22</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>9/22</u> <u>1961</u> , and that death occurred at <u>6:30</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>J M Warren</u> M.D.		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-26-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Queens Chapel</u>		23d. LOCATION (City, town or county) (State) <u>Murkirk, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
ADDRESS <u>Rockville, Md</u>		DATE <u>SEP 28 '61</u>	

VR A15 (4)
15M 9/60

44

1877

1877

1

James H. H. H.

James H. H. H.

James H. H. H.

James H. H. H.

James H. H. H.

James H. H. H.

James H. H. H.

James H. H. H.

James H. H. H.

James H. H. H.

1
TO HOSE 1 OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(C) 050

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) US AIR FORCE HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) e. STATE MARYLAND f. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND d. STREET ADDRESS 3456 HOMER AVENUE • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last DANIEL WAYNE MARSHALL						4. DATE OF DEATH Month Day Year SEPTEMBER 14 19 61					
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 SEPTEMBER 1961				9. AGE (In years last birthday) yrs. Months Days Hours Min. 3 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE				11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME HAROLD GENE MARSHALL						14. MOTHER'S MAIDEN NAME JANET LOUISE TITUS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT FATHER		Address SAME AS ITEM #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY INSUFFICIENCY DUE TO 774X PREMATURE BIRTH WITH IMMATURITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (this hospital) attended the deceased from 12 September 19 61 to 14 September 19 61 , that (we) last saw the deceased alive on 14 September 19 61 , and that death occurred at 200 P M, from the causes and on the date stated above.										INTERVAL BETWEEN ONSET AND DEATH 50 HOURS	
22a. SIGNATURE John A. Moore M.D. 22c. PHYSICIAN'S NAME (Type) JOHN A MOORE, Major USAF MC						22b. ADDRESS USAF HOSPITAL, ANDREWS AFB, WASH 25 DC 22d. ADDRESS USAF HOSPITAL, ANDREWS AFB, WASH 25 DC 22e. REC'D BY REGISTRAR SEP 19 '61 22f. REGISTRAR'S SIGNATURE Arthur S. Kraus					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/16/1961		23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cem.		23d. LOCATION (City, town or county) (State) Suitland Rd/, Pr. Geo. Co., Md.					
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., 517--11th St. S.E. Wash. DC						25a. REC'D BY REGISTRAR SEP 19 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

2050191XV1

10374

10568

M

2

1

NAME: MARSHALL, JOHN
 BIRTH: 12 SEPTEMBER 1901
 PLACE OF BIRTH: MARSHALL, IOWA
 OCCUPATION: LABORER
 STATUS: SINGLE
 RELIGION: METHODIST
 EDUCATION: HIGH SCHOOL
 SERVICE: U.S. ARMY
 GRADE: PRIVATE
 BRANCH: INFANTRY
 ASSIGNMENT: 10374
 ADDRESS: 10568

JOHN A. MOORE, Major USARMC
 USARMC HOSPITAL, ANKANG, CHINA
 14 SEPTEMBER 51
 12 SEPTEMBER 51

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10575

10567

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES.</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - ADELPHI</u> c. LENGTH OF STAY IN 1b <u>5 1/2 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PAINT BRANCH NURSING HOME.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGES.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> <u>58</u> d. STREET ADDRESS <u>2108 Beechwood Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>ANNIE</u> <u>ESTELLE</u> <u>MASON</u>		4. DATE OF DEATH Month <u>9</u> Day <u>19</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 3 - 1892</u>		9. AGE (In years last birthday) <u>89</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BEAUFORT. N.C.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			13. FATHER'S NAME <u>LOUIS ALEXANDER POTTER.</u>				
14. MOTHER'S MAIDEN NAME <u>NETTIE FISH</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				
16. SOCIAL SECURITY NO. <u>NONE</u>			17. INFORMANT Address <u>PAINT BRANCH NURSING HOME RECORD</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac Congestive Heart Failure</u> 420.0 DUE TO Condition, if any, which gave rise to immediate cause (b) <u>Arterio-sclerotic Heart Disease</u> (a), stating the underlying cause last. } DUE TO <u>Chc arricular fibrillation</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 4 1961</u> to <u>Sept 19 61</u> , that (I) (we) last saw the deceased alive on <u>Sept 4 1961</u> , and that death occurred at <u>10:00</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>W.L. ETIENNE</u> M.D.				22b. DATE SIGNED <u>9-19-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>W.L. ETIENNE</u>				22d. ADDRESS <u>College St, Ind.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/22/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>			
23d. LOCATION (City, town or county) (State) <u>BIADENSBURG MD</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>DEAL FUNERAL HOME</u>					
25a. REC'D BY REGISTRAR <u>SEP 21 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

520

式

CERTIFICATE OF DEATH

Reg. Dist. No.

10576

10568

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bell Nursing for Children</u>		d. STREET ADDRESS <u>3713 - Alabama Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Kathleen Mastrosito</u>		4. DATE OF DEATH <u>Sept 13 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-15-1961</u>
9. AGE (In years last birthday) <u>2</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>2</u> Days <u>28</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James Michael Mastrosito</u>		14. MOTHER'S MAIDEN NAME <u>Adelle Minette Sullivan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>James Michael Mastrosito</u>		Address <u>Same as X 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>microcephaly (Cerebral agenesis)</u> 753.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>multiple congenital defects</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Birth on</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/10</u> , 19 <u>61</u> , to <u>9/13</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>9/13</u> , 19 <u>61</u> , and that death occurred at <u>3:10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas A. Christensen</u> M.D.		ADDRESS (Street, city or town, state) <u>College Park</u> DATE SIGNED <u>9/13/61</u>	
PHYSICIAN'S NAME (Type) <u>T. A. Christensen</u>		<u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-15-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Mattingly</u>		ADDRESS <u>131-11th St. S.E.</u>	
24a. REC'D BY REGISTRAR <u>SEP 18 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1913

2

Form with multiple lines for handwritten entry, including fields for name, date, and location. The text is mirrored and difficult to read.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10577

10569

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE — b. COUNTY DISTRICT OF COLUMBIA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLENN DALE		c. LENGTH OF STAY in 1b 4 Yrs, 7 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X WASHINGTON, D.C.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GLENN DALE HOSPITAL				d. STREET ADDRESS 607-6th St. S.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) VIOLET MAY MAXWELL				4. DATE OF DEATH Month 9 Day 3 Year 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/16/22	
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months 2 Days 17		IF UNDER 24 HRS. Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (County & State, or foreign country) RICHMOND, Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME HINCHIE FREEMAN				14. MOTHER'S MAIDEN NAME LAURA BOHANAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. 578-12-6862		17. INFORMANT DECEASED Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS 002X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						INTERVAL BETWEEN ONSET AND DEATH 10 YRS, 34 W.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from 1/4, 1957 to 9/3, 1961 , that he (we) last saw the deceased alive on 9/3, 1961 , and that death occurred at 10:5 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Moie Weiss				M.D. MOE WEISS M.D.		22b. DATE SIGNED 9/3/61	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS GLENN DALE HOSPITAL, GLENN DALE, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-7-61		23c. NAME OF CEMETERY OR CREMATORY Fp Lincoln Cemetery Colman Manor Md.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE F. Darcha Sons Hyattsville, Md				ADDRESS #577		25a. REC'D BY REGISTRAR SEP 8 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

920

51

10

• • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10578

10570

1. PLACE OF DEATH a. COUNTY Prince Georges Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland		c. LENGTH OF STAY IN 1b unknown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5316 Annapolis Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rosa Middle Lee Last Mays		4. DATE OF DEATH Month Sept. Day 5 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/10/1869
9. AGE (In years lost birthday) 92		10. IF UNDER 1 YEAR Months 4 Days 5 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Augusta, Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. Thomas Armstrong		14. MOTHER'S MAIDEN NAME Nancy Heath	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Willie Lee King		Address 5316 Annapolis Rd. Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) UNKNOWN Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4-5 DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/14 19 61 , to 9/5 19 61 , that (I) (we) last saw the deceased alive on 9/2 19 61 , and that death occurred at 4 AM , from the causes and on the date stated above.			
22a. SIGNATURE C. James Duke		22b. DATE SIGNED 9/5/61	
22c. PHYSICIAN'S NAME (Type) C. JAMES DUKE		22d. ADDRESS 6607 RIVERDALE RD, RIVERDALE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 9/6/61	
23c. NAME OF CEMETERY OR CREMATORY West View Cemetery		23d. LOCATION (City, town, or county) (State) Augusta, Georgia	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.		25a. REC'D BY REGISTRAR SEP 7 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

4

1
FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10579 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10571

1. PLACE OF DEATH e. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		
c. LENGTH OF STAY in 1b <u>1 mo</u>			d. STREET ADDRESS <u>4705 Longfellow St</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Selane Memorial Hosp</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Mamie Hannah McElwhirt</u>			4. DATE OF DEATH <u>Sept 6 1961</u>		
5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>March 7, 1895</u>		
9. AGE (In years, last birthday) <u>66</u> yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		
11. BIRTHPLACE (State or foreign country) <u>District of Columbia D. C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		
13. FATHER'S NAME <u>William A. Rutherford</u>			14. MOTHER'S MAIDEN NAME <u>Mary Ann Williams</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>no</u>		
17. INFORMANT <u>Gertrude Krocke, same as #2</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of right hip</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Injury occurred in living room of home</u>		
20c. TIME OF INJURY Month, Day, Year <u>8/4 1961</u>			20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		
20e. (City or town) <u>Riverdale P. D. Md</u>			20f. (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James I. Boyd</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>9/8/61</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>			22d. LOCATION (City, town, or country) (State) <u>Bladensburg, Md.</u>		
23. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>			24a. REC'D BY REGISTRAR <u>SEP 8 '61</u>		
ADDRESS <u>Hyattsville, Maryland</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>		

MEDICAL CERTIFICATION

16

2

1870

①

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]

1870

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10580

10572

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>			c. LENGTH OF STAY IN 1b <u>43 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1) SAME</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>614 MONTGOMERY ST</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>HARLEY</u> Last <u>MERSON</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>23</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 22, 1908</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>PLASTERER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>LEMUEL MERSON</u>				14. MOTHER'S MAIDEN NAME <u>LOLA MERSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-16-262</u>		17. INFORMANT <u>RALPH BAKER 612 MONTGOMERY ST</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL MALACIA</u> 422 ✓ DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u> <u>YRS.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>PRESENT</u> , 19____, that (I) (we) last saw the deceased alive on <u>SEPT 20</u> 19 <u>61</u> , and that death occurred at <u>SA</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>John R. Bueck</u>				22b. DATE <u>9/23/61</u>		22c. PHYSICIAN'S NAME (Type) <u>JOHN R. BUECK</u>	
22a. SIGNATURE <u>John R. Bueck</u>				22b. DATE <u>9/23/61</u>		22c. PHYSICIAN'S NAME (Type) <u>JOHN R. BUECK</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/25/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Long Hill Cemetery Laurel Md</u>		23d. LOCATION (City, town, or county) _____ (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Canadian, Laurel Md</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 26 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10320

10320

M

MADE IN
BOX 10410

CHIFFON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10581

Reg. Dist. No. 10573

1. PLACE OF DEATH a. COUNTY <u>Prince Georges Hospital</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leverly Ind</u>		c. LENGTH OF STAY IN 1b <u>DOA.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General.</u>				d. STREET ADDRESS <u>Route #301</u>			
3. NAME OF DECEASED (Type or print) <u>Keneeth</u> First <u>MOORE</u> Last				4. DATE OF DEATH Month <u>9</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-17-1942</u>		9. AGE (In years last birthday) <u>19</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leonard Moore</u>				14. MOTHER'S MAIDEN NAME <u>Anna Belle Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT <u>John F. Moore</u> Address <u>Upper Marlboro</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and Shock</u> 816 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Fractures of Skull and</u> DUE TO <u>large laceration of occipital area</u> (c) <u>Sudden</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Automobile Collision</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u> <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Collision Highway 301</u>					
20c. TIME OF INJURY Month, Day, Year <u>9-16-1961</u> Hour <u>3:25</u> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Road</u>		20f. (City or town) (County) (State) <u>Highway 301 Prince Georges Ind</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Paul Van Natta</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>PAUL VAN NATA</u> asst				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-21-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Bethel</u>		22d. LOCATION (City, town, or county) (State) <u>T. B. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle K. Rollins</u>				ADDRESS <u>4339 Hunt Pl, N. E.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 20 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10321

1. NAME OF DECEASED Leonard Marie		2. SEX Male	
3. AGE 38		4. DATE OF BIRTH 8-17-1942	
5. PLACE OF BIRTH Wash. D.C.		6. OCCUPATION Police Officer	
7. MARITAL STATUS Married		8. NAME OF SPOUSE Anna Belle Jackson	
9. ADDRESS John F. Moore High School		10. CITY Baltimore	
11. COUNTY Harford		12. STATE MD	
13. DATE OF DEATH 8-21-1980		14. TIME OF DEATH 10:30 PM	
15. CAUSE OF DEATH Heart Disease		16. MANNER OF DEATH Natural	
17. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		18. SIGNATURE OF MEDICAL EXAMINER Dr. J. H. Smith	
19. SIGNATURE OF CORONER Dr. J. H. Smith		20. SIGNATURE OF JURY Dr. J. H. Smith	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10582

Item 2 Film G296 9/26/61 iwk

Reg. Dist. No. 10374

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Hospital</u>				c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u>				d. STREET ADDRESS <u>Rt. 301,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louis</u> First <u>L</u> Middle <u>MOORE</u> Last				4. DATE OF DEATH Month <u>9</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-15-38</u>	
9. AGE (In years last birthday) <u>22</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Lunchroom</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Leonard Moore</u>				14. MOTHER'S MAIDEN NAME <u>Anna Belle Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>213 98 3328</u>		17. INFORMANT <u>John F. Moore</u> Address <u>Upper Marlboro Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and Shock</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fractures of Skull and Crushed Chest</u> DUE TO (c) <u>Sudden</u> Interval between onset and death <u>Sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Collision Highway 301</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9/16</u> 1961 p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 301</u>		20f. (City or town) <u>Pr Georges</u> (County) <u>Md</u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Paul C Van Natta</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>PAUL C VAN Natta</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9-21-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Bethel Church</u>	
22d. LOCATION (City, town, or county) <u>T. B.</u>				22e. (State) <u>Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle R. Collins</u>				ADDRESS <u>4339 Hunt Pl. N.E.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 20 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED John F. M... ..		AGE ...	
SEX Male		RACE White	
DATE OF DEATH ...		PLACE OF DEATH ...	
CAUSE OF DEATH ...		MANNER OF DEATH ...	
SIGNATURE OF EXAMINER ...		DATE ...	
LOCALITY ...		COUNTY ...	
CITY ...		STATE ...	
CITY OF BALTIMORE		STATE OF MARYLAND	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item 2 Film G294 9/11/61 mh											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE MARYLAND b. COUNTY PRINCE GEORGE							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHILHAM 2 yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHILHAM Balto.							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CARROLL MANOR				d. STREET ADDRESS 2017 East 32nd St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY REGINA MORIARTY				f. DATE OF DEATH SEPT. 4, 1961				Day Year			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH JAN. 9, 1877		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CONFECTIONER				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.			
12. CITIZEN OF WHAT COUNTRY? U.S.A				13. FATHER'S NAME JAMES E. MORIARTY				14. MOTHER'S MAIDEN NAME ANN ALBAUGH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. NONE				17. INFORMANT CATHERINE MORIARTY - BALTO, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 421.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Cardiac decompensation (c) Aortic stenosis				INTERVAL BETWEEN ONSET AND DEATH Minutes Years Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (of 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 31, 1961 , to Sept 4, 1961 , that (I) (we) last saw the deceased alive on Sept 3, 1961 , and that death occurred at 9P M, from the causes and on the date stated above.											
22a. SIGNATURE Richard P. DeLaney				M.D. WHEATON, MD.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 9-7-61		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVE		23d. LOCATION (City, town or county) (State) WASH., D.C.			
24. FUNERAL DIRECTOR'S SIGNATURE JAMES T. RYAN, Inc.				ADDRESS 317 Pa. Ave S.E.				25a. REC'D BY REGISTRAR SEP 7 '61		25b. REGISTRAR'S SIGNATURE William L. Hanna	

(M)

(I)

10588

10575

~~James E. McNamee~~

Charles E. McNamee

~~James E. McNamee~~

James E. McNamee

James E. McNamee

James E. McNamee

James E. McNamee

James E. McNamee

James E. McNamee

James E. McNamee

~~James E. McNamee~~

James E. McNamee

James E. McNamee

James E. McNamee

James E. McNamee

James E. McNamee

X

James E. McNamee

James E. McNamee

James E. McNamee

James E. McNamee

James E. McNamee

James E. McNamee

James E. McNamee

James E. McNamee

James E. McNamee

James E. McNamee

James E. McNamee

James E. McNamee

James E. McNamee

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10584 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10576

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

9 hrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

a. STATE

Maryland

b. COUNTY

Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Landover Hills

d. STREET ADDRESS

6916 Annapolis Road

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

Levi

Murray

September 17, 61

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

January 6, 1889

9. AGE (In years last birthday)

72 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Physician

10b. KIND OF BUSINESS OR INDUSTRY

U.S. Govt

11. BIRTHPLACE (State or foreign country)

Missouri

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Jamison Murray

14. MOTHER'S MAIDEN NAME

Sarah Elizabeth Dunlap

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

WW I

16. SOCIAL SECURITY NO.

216-40-0219

17. INFORMANT

Address

Mrs Billie Mae Owens, same as # 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

INTESTINAL HEMORRHAGE

DUE TO

SEVERE hemorrhagic entero-colitis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Aortic Insufficiency; Hypertrophy of heart

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

James I. Boyd

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

9/18/61

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or country)

(State)

BURIAL 9-20-61 ARLINGTON NAT FORT MYER VA

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

W W CHAMBERS CO RIVERDALE MD

DATE SEP 21 '61

Arthur S. Hume

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

X

James S. Cook

James I. Cook

James S. Cook
James I. Cook

CERTIFICATE OF DEATH

Reg. Dist. No. 10577

10585

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pt. Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pedar Hgts.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>904-64-Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>VIRGIE Delydia Myles</u>				4. DATE OF DEATH Month Day Year <u>Sept. 19 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May-28-1882</u>	9. AGE (In years last birthday) <u>79</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Patrick Stewart</u>				14. MOTHER'S MAIDEN NAME <u>Delydia Bell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>DANIEL E. MYLES</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROSIS - GEN'L</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>3-4</u> 19 <u>61</u> to <u>9-19</u> 19 <u>61</u> , that I last saw the deceased alive on <u>9-19</u> 19 <u>61</u> , and that death occurred at <u>1:25 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. B. Beldon</u>				M.D. <u>4-23-1941 - PI. ME</u>			
PHYSICIAN'S NAME (Type) <u>H. C. Beldon</u>				Wash - 19 - DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9/23/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>	
22d. LOCATION (City, town, or county) <u>Suitland, Maryland</u>				(State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Blair Stewart</u>				ADDRESS <u>30 H Street, N.E. Wash; D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 21 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

100-100000

100-100000

100-100000

100-100000

DATE OF DEATH: 10/10/60
PLACE OF DEATH: New York, N.Y.
CAUSE OF DEATH: Myocardial Infarction
MANNER OF DEATH: Natural
DECEASED'S NAME: John Doe
AGE: 45
SEX: Male
RACE: White
BIRTH DATE: 10/10/15
BIRTH PLACE: New York, N.Y.
MARRIAGE DATE: 10/10/40
MARRIAGE PLACE: New York, N.Y.
OCCUPATION: Doctor
EDUCATION: High School
RELIGION: Catholic
MARITAL STATUS: Married
SPOUSE'S NAME: Jane Doe
SPOUSE'S AGE: 40
SPOUSE'S SEX: Female
SPOUSE'S RACE: White
SPOUSE'S BIRTH DATE: 10/10/20
SPOUSE'S BIRTH PLACE: New York, N.Y.
SPOUSE'S MARRIAGE DATE: 10/10/40
SPOUSE'S MARRIAGE PLACE: New York, N.Y.
SPOUSE'S OCCUPATION: Teacher
SPOUSE'S EDUCATION: College
SPOUSE'S RELIGION: Catholic
SPOUSE'S MARITAL STATUS: Married
SPOUSE'S SPOUSE'S NAME: John Doe
SPOUSE'S SPOUSE'S AGE: 45
SPOUSE'S SPOUSE'S SEX: Male
SPOUSE'S SPOUSE'S RACE: White
SPOUSE'S SPOUSE'S BIRTH DATE: 10/10/15
SPOUSE'S SPOUSE'S BIRTH PLACE: New York, N.Y.
SPOUSE'S SPOUSE'S MARRIAGE DATE: 10/10/40
SPOUSE'S SPOUSE'S MARRIAGE PLACE: New York, N.Y.
SPOUSE'S SPOUSE'S OCCUPATION: Doctor
SPOUSE'S SPOUSE'S EDUCATION: High School
SPOUSE'S SPOUSE'S RELIGION: Catholic
SPOUSE'S SPOUSE'S MARITAL STATUS: Married

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10585
CERTIFICATE OF DEATH

Reg. Dist. No. 10578

1. PLACE OF DEATH a. COUNTRY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md.</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Capitol Heights</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Capitol Heights</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>621-51st Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>JOHN WHITE NAIRN</i>		4. DATE OF DEATH <i>Sept 5 1961</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 14, 1893</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>DC Govt.</i>	11. BIRTHPLACE (State or foreign country) <i>Wash DC</i>
13. FATHER'S NAME <i>Geo. W. Nairn</i>		14. MOTHER'S MAIDEN NAME <i>Mary J. White</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes 1918-1919</i>		17. INFORMANT <i>Mrs. J. Nairn - 621-51st Ave Capitol Heights md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Coronary</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Heart Disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <i>May 26, 1959</i> to <i>Sept 5, 1961</i> , that I last saw the deceased alive on <i>Sept 3, 1961</i> , and that death occurred at <i>7:30 A.M.</i> from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>William Brainin</i> M.D.		ADDRESS (Street, city or town, state) <i>6124 Central Ave</i> DATE SIGNED <i>9/5/61</i>	
PHYSICIAN'S NAME (Type) <i>WM BRAININ</i>		<i>Capitol Heights md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/8/61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>	22d. LOCATION (City, town, or county) (State) <i>Arlington, Va.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis Gasch's Sons</i> ADDRESS <i>Hyattsville, Maryland</i>		24a. REC'D BY REGISTRAR <i>SEP 7 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11-28

NAME

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERIODICITY

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
M
10587
M
10579

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 16 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 5601 36th Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frances A 4. DATE OF DEATH Noon Sept. 27 19 61		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 19 March 1909 9. AGE (In years, last birthday) 52 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY own home 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Unk. 14. MOTHER'S MAIDEN NAME Inez Trail	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. no 17. INFORMANT Peter T Noon Address Hyattsville Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 578X DUE TO Conditions, if any, which gave rise to immediate cause (b) Perforation of Diverticulum of ascending Colon (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at....., 19....., from the causes and on the date stated above. 11, 30P M.			
22a. SIGNATURE Dr. A. Deitz 22c. PHYSICIAN'S NAME (Type) Dr. A. Deitz, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Hyattsville, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Sept 30, 1961 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery 23d. LOCATION (City, town or county) (State) Colmar Manor Md.		25a. REC'D BY REGISTRAR DATE OCT 2 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kline	
24. FUNERAL DIRECTOR'S SIGNATURE Gasch's Sons ADDRESS Hyattsville, Md.			

M

4

Anthony S. Kraus

VS. A15ME
5M 7/59

10220

10222

(M)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
10589
Item 3 Film G297 10/2/61
10581

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Prin George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Suitland Md</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tuxedo</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Walle Lane</i>		d. STREET ADDRESS <i>5500 Tuxedo Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Mattie</i> Middle <i>G.</i> Last <i>Owens Owens</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>4</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 14, 1885</i>
9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Jacob Watts</i>		14. MOTHER'S MAIDEN NAME <i>Mattie Lowman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Virginia Gibbs - Kentland Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic carcinoma of breast</i> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Aug 20, 1961</i> to <i>Sept 4, 1961</i> , that (I) (we) last saw the deceased alive on <i>Sept. 3 1961</i> , and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Paul A. Devore</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>PAUL A. DEVORE</i> 22d. ADDRESS <i>3501 HAMILTON ST. - HYATTSVILLE, MD</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>9/7/61</i>	
23c. NAME OF CEMETERY OR CREMATORIUM <i>Ceder Hill</i>		23d. LOCATION (City, town, or county) (State) <i>Suitland Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Maryland</i>	
25a. REC'D BY REGISTRAR <i>SEP 13 61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	

1911

1911

1911

5



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10590

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8320 Old Fort Rd. E.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Friendly</u> d. STREET ADDRESS <u>8320 Old Fort Rd. E.</u>					
3. NAME OF DECEASED (Type or print) <u>Mary A Palmer</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>14</u> Year <u>1961</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH <u>April 17, 1894</u>		9. AGE (In years last birthday) <u>69</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.								
Months	Days								
Hours	Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>					
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>							
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>							
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Rosalie Jackson, 8320 Old Fort Rd. E.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>Cardiac Decompensation</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u> <u>10 years</u> <u>5 days</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>5-1-56</u> , 19 <u>56</u> , to <u>9-14-61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>9/13/61</u> , 19 <u>61</u> , and that death occurred at <u>12</u> p.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7519 Broadview Rd. S.E.</u> DATE SIGNED <u>9/14/61</u> ACTUAL SIGNATURE <u>Anna Coyne Todd</u> M.D. PHYSICIAN'S NAME (Type) <u>Anna A. Coyne Todd</u> <u>Pr. Geo. Md.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-16-61 BURIAL</u>		22b. DATE THEREOF <u>9-16-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NAT. HARMONY</u>					
22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGES COUNTY MD</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Pines Co. 3015-12th St. N.E. Washington, D.C.</u>							
24a. REC'D BY REGISTRAR DATE <u>SEP 18 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

10591

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.				c. LENGTH OF STAY IN 1b 1 year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8405 Patuxent avenue,.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Ephriam Last Pannebaker				4. DATE OF DEATH Month Sept Day 30 Year 19 61-			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 20, 1909	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Social Security		11. BIRTHPLACE (State or foreign country) Washington D C	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Gustave B Pannebaker				14. MOTHER'S MAIDEN NAME Mamie Jacobs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT Helen E Pannebaker Address College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) 15'							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1948 to Sept 19 61 , that (I) (we) last saw the deceased alive on 9-22-61 , and that death occurred at 11 P M, from the causes and on the date stated above.							
22a. SIGNATURE W. L. Etienne				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 10-1-61 SIGNED	
22c. PHYSICIAN'S NAME (Type) W. L. ETIENNE				22d. ADDRESS 4113 Berwyn Rd College Park			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 4, 1961		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville Md.				25a. REC'D BY REGISTRAR DATE OCT 2 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10592

10584

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lanham			c. LENGTH OF STAY IN 1b Transient		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) In a wooded area back of his home					
3. NAME OF DECEASED (Type or print) First High Middle Carter Last Paris			4. DATE OF DEATH Month September Day 6 Year 19 61		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1909	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months 52 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Railway Express Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME John Paris			14. MOTHER'S MAIDEN NAME Sarah Suit		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name unknown) No (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Winifred T. Baldwin, 6034 Telegraph Rd Lanham, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and Shock DUE TO (b) Shot Gun Wound of the Head DUE TO (c) 9776 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Want to the edge of the woods and shot self					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 6-12 x 9/6/ 61		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) In a wooded area Lanham P.G. Md	
20f. (City or town) (County) (State) Lanham P.G. Md					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		M.D.		DATE SIGNED 9/6/61	
EXAMINER'S NAME (Type) James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/9/61		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	
22d. LOCATION (City, town, or country) (State) Colmar Manor, Md.		22e. REC'D BY REGISTRAR SEP 8 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	
23. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Maryland		24a. REGISTRAR'S SIGNATURE	

THE
BATH

10081

10081

Prince George's
Maryland
London
Transient
In a wooded area back of his home
Good luck Road

Male
White
Truck Driver
John Davis
June 22, 1902
Railway Avenue Maryland
Sarah Bell
September 2
U.S.A.

to
Wanted T. Baldwin
604 Telegraph Rd
London, Md
Hemorrhage and Shock
Shot and wound of the head

Went to the edge of the woods and shot self
In a wooded area London P.D. Md

James I. Boyd
Francis Green's home
Baltimore, Maryland
Colonel
Sleight
X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
M
09
I
O
1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eleven Cedars		d. STREET ADDRESS 4336 Claggett Road	
3. NAME OF DECEASED (Type or print) Anna First Middle L. Last Parsons		4. DATE OF DEATH Sept. 24, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1870
9. AGE (In years and birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Christopher Buttner		14. MOTHER'S MAIDEN NAME Rebecca Stanzey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Albert B. Parsons Same as #2 Son		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Anterior Wall Heart Disease (b) c. Acute Cardiac (c) Deep Vein Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-4 1950, to 9-24 1961, that (I) (we) last saw the deceased alive on 9-22 1961, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE A. B. Parsons		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/26/61	
23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland	
25a. REC'D BY REGISTRAR DATE SEP 27 '61		25b. REGISTRAR'S SIGNATURE	

(15)

1 2 3 4

2 - 3 - 4 - 5

C. H. May, Jr. D.D. CC

5.

5.25.2008

[illegible]

100

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10594 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10586

1
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission) a. STATE Maryland Prince George's b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bellemead, Hyattsville			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 37		d. STREET ADDRESS 4000 - 74th. Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital							
3. NAME OF DECEASED (Type or print) Loretta Lynn Paugh				4. DATE OF DEATH Month Sept. Day 10, Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 20, 1961	
9. AGE (In years last birthday) 2 21		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Guy William Paugh				14. MOTHER'S MAIDEN NAME Mary Jo Hallisey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mary Jo Hallisey		Address same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to 924.0 DUE TO Suffocation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Caught between mattress and side of crib							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 7:20xx 9/10 19 61				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> Home			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home				20f. (City or town) Hyattsville P.G. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James I. Boyd</i>				DATE SIGNED Sept. 10, 1961			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9-13-1961			
22c. NAME OF CEMETERY OR CREMATORY Arlington National				22d. LOCATION (City, town, or country) Arlington, Virginia			
23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.				24a. REC'D BY REGISTRAR SEP 13 '61			
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>							

2077409XV5

(M)

(I)

Prince George's

Maryland

Prince George's

Cheverly

Beltsville, Maryland

Prince George's General Hospital

4000 - 7th Place

Loraine

Lynn

French

Sept. 10, 1961

MI

Female White

June 20, 1961

9 21

None

None

Maryland

USA

Gay William Pugh

Mary Jo Kelley

None

Mary Jo Kelley

same as 42

Analysis due to

Salmonella

Daughter between father and wife of child

Home

Beltsville, Md.

X

X

X

Sept. 10, 1961

JAMES I. BORD, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10595

10587

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bladensburg d. STREET ADDRESS 5437 Taussig Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Anna K. Pfeifer		4. DATE OF DEATH Month Day Year September 1 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 26, 1918 13 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (County & State, or foreign country) Pa
13. FATHER'S NAME Ralph Denniston		14. MOTHER'S MAIDEN NAME Mary Eates	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		17. INFORMANT Fred D Pfeifer Address Bladensburg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute congestive heart failure</i> 252.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Ventricular fibrillation</i> DUE TO (c) <i>Chronic thyrotoxicosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs.</i> <i>4 hrs.</i> <i>1 yr.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Azotemia</i>			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Bladensburg Md.
21. I certify that (I) (this hospital) attended the deceased from <i>8/18</i> to <i>8/31</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>8/31</i> , 19 <i>61</i> , and that death occurred at <i>9:30</i> AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Barry Rosenberg</i> 22c. PHYSICIAN'S NAME (Type) Barry Rosenberg, M.D.		22b. DATE SIGNED September 1, 1961 22d. ADDRESS 1210 Chillum Manor Rd., W. Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 5, 1961	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City, town or county) (State) Silver Springs, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph's Funeral Home</i>		25. REC'D BY REGISTRAR SEP 7 '61 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

(M)

10033

10033

no
high
own home
very sales
Blanchard, WI.

Blanchard, WI.
Blanchard, WI.
Blanchard, WI.

Blanchard, WI.
Blanchard, WI.
Blanchard, WI.

may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10596

Items 0 & 9 Film G295 9/25/61 iwk

10588

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
c. LENGTH OF STAY IN 1b <u>5 years</u>		d. STREET ADDRESS <u>2619 Nicholson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2619 Nicholson st</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>Preikszas</u> Last <u>Preikszas</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 22, 1908</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Mary ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Otto J Preikszas</u>		Address <u>Hyattsville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral of rectum met</u> 154X DUE TO <u>metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastasis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>15 mo</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-27</u> <u>1961</u> to <u>9-11</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>8-11</u> <u>1961</u> , and that death occurred at <u>5:42</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Rowland F. Wilkinson</u>		22b. DATE SIGNED <u>9-13-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Rowland F. Wilkinson M.D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept 15, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Md.</u>	
25a. REC'D BY REGISTRAR <u>SEP 18 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

10532

(14)

Wesleyville, N.Y.
Wesleyville, N.Y.

(1)

Wesleyville
Wesleyville

Wesleyville
Wesleyville

U.S.A.

Wesleyville, N.Y.

Wesleyville, N.Y.

Wesleyville, N.Y.

Wesleyville, N.Y.

Wesleyville, N.Y.

Wesleyville, N.Y.

Wesleyville, N.Y.

Wesleyville, N.Y.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10597

CERTIFICATE OF DEATH

Reg. Dist. No.

10589

1. PLACE OF DEATH a. COUNTY Pr. George Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Hgts.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home		d. STREET ADDRESS 2349 Iverson St. S. E.	
3. NAME OF DECEASED (Type or print) First Catherine Middle E. Last Quigley		4. DATE OF DEATH Month Sept. Day 12, Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1880
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 80 Days 80 Hours 80 Min.	IF UNDER 24 HRS. Months 80 Days 80 Hours 80 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Wash. Term. Co.	
11. BIRTHPLACE (State or foreign country) Wash. D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Quigley		14. MOTHER'S MAIDEN NAME Rose Dougherty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	
INFORMANT Mary Quigley		Address 2349 Iverson St. S.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive Heart Failure DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1955 to 9/12, 1961 , that I last saw the deceased alive on 9/19, 1961 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE David Lenarduzzi		ADDRESS (Street, city or town, state) DATE SIGNED 2901 Fairlawn St. SE Wash, D.C. 9/12/61	
PHYSICIAN'S NAME (Type) David Lenarduzzi		Wash, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 15, 1961	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	22d. LOCATION (City, town, or county) (State) Wash. D.C.
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc.		24a. REC'D BY REGISTRAR SEP 15 '61	
ADDRESS 317 Penna. Ave. S.E.		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

15581

(M)

(1)

MEDICAL CERTIFICATION

VS A1S (4)
ISM 10/S7

1

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. AISME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10599 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHEVERLY				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BRANDYWINE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PRINCE GEORGES GENERAL				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED First Middle Last CHARLES ALBERT RICHARDSON				4. DATE OF DEATH Month Day Year SEPT. 14, 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 13, 1888	
9. AGE (in years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN William RICHARDSON		14. MOTHER'S MAIDEN NAME ELLEN ELIZABETH BALL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes give number or date of service)		17. INFORMANT Address MARIE RICHARDSON, BRANDYWINE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Heart disease (a), stating the underlying cause last. DUE TO (c) inst PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral accident 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. no		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> While not at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 9-14-61							
ACTUAL SIGNATURE Dayton Watkins		EXAMINER'S NAME (Type) DAYTON O WATKINS		DATE SIGNED 9-14-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-17-61		22c. NAME OF CEMETERY OR CREMATORY ST PAULS		22d. LOCATION (City, town, or country) (State) BADEN, MARYLAND	
23. FUNERAL DIRECTOR ADDRESS THE HUNTT FUNERAL HOME, WALDORF, MD.				24a. REC'D BY REGISTRAR DATE SEP 20 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Knepp	

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10600

CERTIFICATE OF DEATH

10593

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Pr. Geo. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington, D. C. d. STREET ADDRESS 8200 Largo Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Vincent		First Richardson		Middle Richardson		Last Richardson		4. DATE OF DEATH September 18 19 61			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-25-98		9. AGE (in years last birthday) 62 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Share-cropper		11. BIRTHPLACE (County & State, or foreign country) Prince George's Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John Richardson				14. MOTHER'S MAIDEN NAME Elizabeth Richardson							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or date of service)		17. INFORMANT Mrs. E Josephine Richardson, Wife					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 592X IMMEDIATE CAUSE (a) Electrolyte Imbalance DUE TO Ch. renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 9/17 1961 to 9/18 1961 , that (I) (we) last saw the deceased alive on 9/17 1961 , and that death occurred at 5:30 AM , from the causes and on the date stated above.											
22a. SIGNATURE C. Louis Mendel M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9/19/61					
22c. PHYSICIAN'S NAME (Type) C. LOUIS MENDEL, M.D.				22d. ADDRESS 4506 COLLEGE AVE COLLEGE PARK Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/21/61		23c. NAME OF CEMETERY OR CREMATORY Holy Family Cemetery		23d. LOCATION (City, town or county) (State) Mitchville, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Alex S. Pope Jr.				ADDRESS 414 15th. St. S. E.		25a. REC'D BY REGISTRAR SEP 20 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

VR A15 (4)
15M 9/60

10553

10553

M

1

10553

10553

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any may be necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY		Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE		Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cheverly		c. LENGTH OF STAY IN 1b		33		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Kentland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Prince George's General Hospital		d. STREET ADDRESS		7710 Greeley Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Middle Last		3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
5. SEX		Female		6. COLOR OR RACE		White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
										9. AGE (In years last birthday)	
										74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		House work		10b. KIND OF BUSINESS OR INDUSTRY		At Home		11. BIRTHPLACE (State or foreign country)		Italy	
13. FATHER'S NAME		John Yours		14. MOTHER'S MAIDEN NAME		Unknown		12. CITIZEN OF WHAT COUNTRY?		USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		No		16. SOCIAL SECURITY NO.		None		17. INFORMANT		Address	
								Harry R. Rithman		3500 - 37th. Ave., Colmar Manor, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		442X		DUE TO		Acute congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH	
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO		Cardiovascular renal disease			
		(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Diabetes								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		James I. Boyd		JAMES I. BOYD, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		JAMES I. BOYD, M.D.				Address (Street, city, town, or county)		DATE SIGNED		Sept. 12, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		22b. DATE THEREOF		9-15-61		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR		Thompson		23a. REC'D BY REGISTRAR		SEP 14 '61		24b. REGISTRAR'S SIGNATURE			
Timothy Han		101 Fun Ho 3831 GA Ave NW									

101

Prince George's

Kentland

Prince George's

Chesley

Kentland

Prince George's General Hospital

WFO Grealy Road

London Mary Richmond

Female White

May 3, 1927

House work

At Home

Italy

John Jones

London

No

None

Harry R. Richmond

3800 - 27th Ave.
College Park, Md.

Acute congestive heart failure

Cardiovascular renal disease

Diabetes

JAMES I. BOND, M.D.

Sept. 12, 1927

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10602					10595						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY			PRINCE GEORGES		a. STATE			MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			ANDREWS AIR FORCE BASE		b. COUNTY			PRINCE GEORGES			
c. LENGTH OF STAY IN 1b			18 HRS 30 MIN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			CAPITOL HEIGHTS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
US AIR FORCE HOSPITAL					615 49TH AVENUE						
3. NAME OF DECEASED			4. DATE OF DEATH			5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
(Type or print)			(Type or print)			(Type or print)					
TERRY			LEA			ROBINSON					
5. SEX			6. COLOR OR RACE			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			8. DATE OF BIRTH		
FEMALE			CAUCASIAN			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			16 SEPTEMBER 1961		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
NONE			NONE			MARYLAND			UNITED STATES		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
JAMES A ROBINSON					MARJORIE L YOYK						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT	
NO					NONE					Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)								3 HOURS			
7610 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								(b) POSSIBLE CENTRAL NERVOUS SYSTEM DAMAGE			
								18 HOURS			
								(c) DIFFICULT LABOR AND DELIVERY			
								18 HOURS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) XXXXXX attended the deceased from 16 SEPT 19 61 to 17 SEPT 19 61, that (I) XX last saw the deceased alive on 17 SEPT 19 61, and that death occurred at 745A M, from the causes and on the date stated above.											
22a. SIGNATURE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS		17 SEP 61			
RICHARD P MALSAN CAPT USAF MC						USAF HOSP, ANDREWS AFB, WASH 25 DC					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
BURIAL			21 SEPT 1961					BATH MAINE			
24. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Rinaldi Funeral Home Inc				816 H St. N.E. DC		DATE SEP 21 '61		Arthur L. Thomas			

2050192XV4

10303

10303

(M)

(C)

642 48TH AVENUE

US AIR FORCE HOSPITAL

SEPTEMBER 17

ROBINSON

AREA

TERRY

16 SEPTEMBER 1961

FEWELL - CAUCASIAN

UNITED STATES

HAWAIIAN

WOMEN

WOMEN

HAROLD L. YORK

JAMES A. ROBINSON

WOMEN

NO

(I)

RESPIRATORY FAILURE

POSSIBLE CENTRAL NERVOUS SYSTEM DAMAGE

DIFFICULT LABORS AND DELIVERY

AT

02 17 SEPT

16 SEPT

WOMEN

17 SEPT

RICHARD V. HALLAM CAPT USAF MC USAF HOSP, ANKUMS AFB, WASH DC

Page 1 of 1

FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10596

10603

CERTIFICATE OF DEATH

Items 11, 12, 13 & 14 Film 8294 9/8/61 1wk

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1/2 hr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 62 Hyattsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 1 4105 Kennedy Street							
3. NAME OF DECEASED (Type or print) Edwin		First Middle Last Rodman		4. DATE OF DEATH Sept. 2 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 Nov 1900		9. AGE (In years last birthday) 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meter Reader		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edward P. Rodman		14. MOTHER'S MAIDEN NAME Alice Adams							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.9 DUE TO Arterio-sclerotic occlus. Rheum. Ar. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Ar. Dis. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4-1-1961 to 9-2-1961, that (I) (we) lost saw the deceased alive on 9-2-1961, and that death occurred at 3:00 AM from the causes and on the date stated above.									
22a. SIGNATURE Dr. A. Deitz		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) Dr. A. Deitz M.D.		22d. ADDRESS Hyattsville., Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/5/61		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Bladensburg Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Real Funeral Home		ADDRESS 4212 G.D. AVE. WASH, D.C.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
				DATE SEP 5 '61					

10520

CENTINATO OR DEATH

10003

10



10



1
FOR STATE
HEALTH DEPT
M
X
I
TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Items 7 & 14 Film 9301 11/22/61 iwk											
1. PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill		c. LENGTH OF STAY IN 1b 30 minutes		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ABC Drive In		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville		d. STREET ADDRESS 5438 Spring Street					
3. NAME OF DECEASED (Type or print) Hattie Pearl Rowe		First Middle Last		4. DATE OF DEATH September 23, 1961		Month Day Year					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug, 25, 1905		9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Walter W. LaMaster		14. MOTHER'S MAIDEN NAME Madden Kilgore		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT 5645 Maxwell Drive Walter W. Rowe, Washington 23, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INFARCT HEART 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY THROMBOSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED September 24, 1961			
ACTUAL SIGNATURE James I. Boyd		EXAMINER'S NAME (Type) James I. Boyd		22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 9/27/61		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) Arlington, Virginia	
23. FUNERAL DIRECTOR W.W. Chambers Co. Washington D.C.		ADDRESS		24a. REC'D BY REGISTRAR SEP 26 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

(M)

1004

10587

Prince George's
30 minutes
Oxon Hill
ABC Drive in
Hattie
Female
Practitioner
U.S. Govt.
Towson
U.S.A.

Walter W. Hester
6545 Oxwell Drive
Washington 25, D.C.

James I. Boyd
James I. Boyd

James I. Boyd
9/27/61
Washington National
Arlington, Virginia
September 28, 1961
W. Chambers Co. Washington D.C.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, end in any event within 12 hours after death.

VS. AISME
SM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10605 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10598									
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale					c. LENGTH OF STAY IN lb 1515				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital					d. STREET ADDRESS Burtonsville				
3. NAME OF DECEASED (Type or print) Sante					4. DATE OF DEATH September 9, 1961				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH September 15, 1870				
9. AGE (In years last birthday) 90					10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer					10b. KIND OF BUSINESS OR INDUSTRY Farming				
11. BIRTHPLACE (State or foreign country) Italy					12. CITIZEN OF WHAT COUNTRY Italy				
13. FATHER'S NAME Antonio Santini					14. MOTHER'S MAIDEN NAME Eurosia Grilli				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None				
17. INFORMANT Anthony P. Santini					Address Same as #2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of the right Hip DUE TO Conditions, if any, which gave rise to immediate cause (b) Terminal pneumonia (c) Terminal pneumonia DUE TO cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Fell walking in the bathroom				
20c. TIME OF INJURY Month, Day, Year 10:00 a.m. 9/5/61					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home					20f. (City or town) Burtonsville (County) Montgomery (State) MD				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE James I. Boyd					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DATE SIGNED Sept. 9, 1961				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF Sept 12, 1961				
22c. NAME OF CEMETERY OR CREMATORY St Marys Cem.					22d. LOCATION (City, town, or country) Laurel, Maryland				
23. FUNERAL DIRECTOR Witt Donaldson, Laurel, Md.					24a. REC'D BY REGISTRAR SEP 15 '61				
					24b. REGISTRAR'S SIGNATURE Arthur J. Kraus				

(M)

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2 1
M
10606
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
10599

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY c. LENGTH OF STAY IN 1b PRINCE GEORGE'S GENERAL HOSPITAL d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEST HYATTSVILLE d. STREET ADDRESS 6923 15TH AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) JOHN First SAUNDERS Middle Last		4. DATE OF DEATH SEPT. 23 1961 Month Day Year		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 4, 1871 9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Fauquier Co. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Leverett J. Saunders				14. MOTHER'S MAIDEN NAME Lucy V. Lomax				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None				16. SOCIAL SECURITY NO. None				17. INFORMANT Ethel L. Saunders West Hyattsville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Bronchogenic Carcinoma (right lower lobe) (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)												INTERVAL BETWEEN ONSET AND DEATH unknown							
21. I certify that (I) (this hospital) attended the deceased from 9/23/61 to 9/23/61, 1961 that (I) (we) last saw the deceased alive on 9/23/61, 1961, and that death occurred at 11:30 A.M. from the causes and on the date stated above.												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
22a. SIGNATURE Dr. Samuel J. Sugar, M.D.				22b. DATE SIGNED SEP 26 1961				22c. PHYSICIAN'S NAME (Type) Dr. Samuel J. Sugar, M.D.				22d. ADDRESS 4637 Eastern Ave., Washington, 18 D.C.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9/26/61				23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln				23d. LOCATION (City, town or county) (State) Bladensburg Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				25a. REC'D BY REGISTRAR SEP 26 1961				25b. REGISTRAR'S SIGNATURE Arthur S. Kinn				25c. DATE							

(M)

10008

10008

Retired Guard

U.S. Govt.

Frederick Co. Virginia

U.S.A.

Levett J. Saunders

Lacy V. Lomax

No

None

8985 18th Ave.

Levett J. Saunders West Lafayette, Ind.

Levett J. Saunders

Levett J. Saunders (not in file)

April 1, 1961

Fort Lincoln

Bladenburg Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
15M 9/59

1
10607
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10600

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 4204 Harford Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lilly Schmidt		4. DATE OF DEATH Month Day Year Sept. 3 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 July 1883
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christian Schmidt		14. MOTHER'S MAIDEN NAME Emilie Toebke	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Address 4204 Harford Terrace Balto. 14, MD.		MISS MARGUERITE SCHMIDT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Occlusion left an art (b) Cent. atherosclerosis Ht des. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 5 days 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus 2 yrs.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 30 Aug 19 61 to 3 Sep 19 61, that (I) (we) last saw the deceased alive on 2 Sep 19 61, and that death occurred at 3:45 PM from the causes and on the date stated above.			
22a. SIGNATURE Thomas J Maloney		22b. DATE SIGNED 3 Sep 61	
22c. PHYSICIAN'S NAME (Type) Dr. T. Maloney., M., D.		22d. ADDRESS 4817 71st Ave. Landover Hills Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/6/61	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY		23d. LOCATION (City, town, or county) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HENRY SANDER & SONS INC. BALTO. MD.		25a. REC'D BY REGISTRAR DATE SEP 6 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Huns			

10000

CERTIFICATE OF DEATH

10000

(M)

(I)

VR A15 (4)
15M 9/60

10001

10003

M

William H. H. H.

William H. H. H.

William H. H. H.

William H. H. H.

William H. H. H.

William H. H. H.

William H. H. H.

William H. H. H.

William H. H. H.

William H. H. H.

William H. H. H.

William H. H. H.

William H. H. H.

William H. H. H.

William H. H. H.

William H. H. H.

William H. H. H.

William H. H. H.

William H. H. H.

William H. H. H.

William H. H. H.

William H. H. H.

William H. H. H.

William H. H. H.

10003

10003



Prince George's

Colony

James Earl Ray

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10603

10610

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) e. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN 1b 8 days				d. STREET ADDRESS 1231 Tee St., N.W.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Clem - Sloan				4. DATE OF DEATH Month Day Year 9 5 19 61			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Unknown		8. DATE OF BIRTH 9/2/1890	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (County & State, or foreign country) Unknown	
12. CITIZEN OF WHAT COUNTRY? Unknown							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown				16. SOCIAL SECURITY NO. -		17. INFORMANT Mrs. Wiggley D.C. General Hospital, Md. Service	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma, right lung 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/28 1961 to 9/5 1961, that (I) (we) last saw the deceased alive on 9/5 1961, and that death occurred at P.M. from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				22b. DATE SIGNED 9/5/61			
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 9-12-61		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town or county) (State) 4611 Benning Rd., S.E. Wash. D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Malvin - Schey Inc 4249 St NW				25a. REC'D BY REGISTRAR SEP 11 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2020

0139

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10604

1. PLACE OF DEATH a. COUNTY 10611 Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 4013 Calvert Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy First Middle Last Slunt		4. DATE OF DEATH Month Day Year September 12 1961	
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/12/61 9. AGE (In years last birthday) yrs. 1 54 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Prince Georges, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bryan M. Slunt		14. MOTHER'S MAIDEN NAME Cheryl Lee Weaver	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hydrocephalous, marked, congenital 752X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/12 19 61 , to 9/12 19 61 , that (I) (we) last saw the deceased alive on 9/12 19 61 , and that death occurred 4:50 P. from the causes and on the date stated above.			
22a. SIGNATURE Herbert J. Friedel M.D.		22b. DATE SIGNED 9/15/61	
22c. PHYSICIAN'S NAME (Type) HERBERT J. FRIEDEL		22d. ADDRESS 6826 RIGGS RD, HYATTSVILLE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 9-18-61	
23c. NAME OF CEMETERY OR CREMATORY Prince Geo.Gen.Hospital		23d. LOCATION (City, town or county) (State) Cheverly, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr., Administrator		25a. REC'D BY REGISTRAR DATE SEP 21 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

VR A15 (4)
15M 9/60

2077171XV/8

10804

10811

(M)

(S)

(I)

[Faint, mostly illegible text covering the page, possibly bleed-through from the reverse side. Some words like "HANGER" and "PICKET" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10612

10605

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b Prince George's General Hospital d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS RFD Box 3303 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy Smith		4. DATE OF DEATH Month September Day 11 Year 1961	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 11, 1961
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) Prince Georges Co., Md.	
13. FATHER'S NAME Leroy M. Smith		14. MOTHER'S MAIDEN NAME Shirley Ann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) Atlectasis Pneumonia INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/11 , 19 61 , to 9/11 , 19 61 , that (I) (we) last saw the deceased alive on 9/11 , 19 61 , and that death occurred at 9:20 , from the causes and on the date stated above.			
22a. SIGNATURE Dr. John W. Perkins M.D.		22b. DATE SIGNED P.M. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Dr. John W. Perkins		22d. ADDRESS 5301 Hamilton St., Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 9-16-61	
23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		23d. LOCATION (City, town or county) (State) Cheverly, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Narry W. Penn, Jr.		25a. REC'D BY REGISTRAR SEP 19 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Hume			

VR A15 (4)
15M 9/60

10000

10012

M

1

Handwritten signature

Handwritten signature

General George S. Patton, Jr.

General George S. Patton, Jr.

Handwritten signature

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>5360-Oxon Hill Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Blanche Maryette Smith</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>23</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-23-1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Belleve Area, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Williams</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577460503</u>	
17. INFORMANT <u>Thelma Tanner Barnabas</u>		Address <u>6250-St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchiogenic Carcinoma (left lung)</u> 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DUE TO</u> (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>about 6 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1, 1961</u> , to <u>Sept. 23, 1961</u> , that I last saw the deceased alive on <u>Sept. 21, 1961</u> , and that death occurred at <u>11:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3560-13th St. N.W. Wash. D.C.</u> DATE SIGNED <u>9-24-61</u>			
ACTUAL SIGNATURE <u>Kenneth G. Brown</u>		PHYSICIAN'S NAME (Type) <u>Kenneth G. Brown - 3560-13th St. N.W.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9-27-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Methodist Church Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Oxon Hill, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A. Twing</u>		24a. REC'D BY REGISTRAR <u>SEP 27 '61</u>	
ADDRESS <u>2500 N. York</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1901

M

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is filled out with handwritten text.

NAME: *John Doe*
AGE: *45*
SEX: *Male*
RACE: *White*
OCCUPATION: *Farmer*
CAUSE OF DEATH: *Heart Disease*
PLACE OF DEATH: *Home*

VS. A15ME
5M 9/60



Princess Georges County
Maryland
Harris Station
19 Days
Princess Georges General Hospital 3225 Perry Street

WATERLINE J.
Dec. 15, 1910
Female, white

U.S.A.
[Faint, mostly illegible text and markings, including several 'X' marks.]

September 11, 1901
JAMES I. HODG, M. D.
[Faint, mostly illegible text and markings.]

10615

CERTIFICATE OF DEATH

Reg. Dist. No.

10808

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel c. LENGTH OF STAY IN 1b Laurel d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital, Inc				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel d. STREET ADDRESS 507 Gorman Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Kathryn Stanton				4. DATE OF DEATH Month Day Year September 17 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 19, 1916	
9. AGE (In years last birthday) 45 Yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Darsey Keys				14. MOTHER'S MAIDEN NAME Elmira Mae Baublitz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Guberoachoid Hemorrhage DUE TO 330X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital Aneurysm DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/1 , 19 40 to 9/17 , 19 61 , that I last saw the deceased alive on 9/17 , 19 61 , and that death occurred at 10:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 307 Prince George Street, Laurel, Md. DATE SIGNED 9/18/61							
ACTUAL SIGNATURE J M Warren							
PHYSICIAN'S NAME (Type) John M. Warren, M.D. 307 Prince George Street, Laurel, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/20/61		22c. NAME OF CEMETERY OR CREMATORY Trinity Hill Cemetery		22d. LOCATION (City, town, or county) (State) Laurel, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE DeWitt Donaldson, Laurel, Md.				24a. REC'D BY REGISTRAR DATE SEP 26 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

TO BE SIGNED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1915

PLACE OF BIRTH
DATE OF BIRTH
SEX
MARRIED
OCCUPATION
CAUSE OF DEATH
PLACE OF DEATH
DATE OF DEATH
SIGNATURE OF REGISTRAR
SIGNATURE OF PHYSICIAN
SIGNATURE OF CLERK

(M)

(1)

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

X

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10616 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institutions, indicate before admission) a. STATE Md. b. COUNTY Montgomery					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clinton						c. LENGTH OF STAY IN 1b Transient					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rear of Hyde Field in Gravel Pit						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring					
d. STREET ADDRESS Rt 2						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Wallace Franklin Stephens						4. DATE OF DEATH Month September Day 19 Year 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 3, 1942		9. AGE (in years last birthday) 18 yrs.		10. IF UNDER 1 YEAR Months 10 Days 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Contractor		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Charles C Stephens						14. MOTHER'S MAIDEN NAME ETTA Briggs					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No						16. SOCIAL SECURITY NO. CHARLES C Stephens - Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Crushed skull (c) Crushed skull DUE TO (e), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Truck loaded with gravel turned over on him					
20c. TIME OF INJURY Hour 9:20xx a.m. Month, Day, Year 9/19 1961		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Gravel pit		20f. (City or town) (County) (State) Clinton P.G. Md					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) James I. Boyd						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DATE SIGNED 9/19/61					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL						22b. DATE THEREOF Sept 22, 1961					
22c. NAME OF CEMETERY OR CREMATORY Potomac Baptist Church Cemetery						22d. LOCATION (City, town, or country) (State) King George Co. VA.					
23. FUNERAL DIRECTOR Arthur S. Henth						24a. REC'D BY REGISTRAR SEP 25 '61					
24b. REGISTRAR'S SIGNATURE Arthur S. Henth											

10015

EMMOE GEORGE'S

CLINSON

TRANSIENT

near of Hyde Field in gravel pit

Wellness Franklin see none

Wife

Hemorrhage on shock

Unshod again

From loaded with gravel turned over on him

FROM K. W. B. BY K. W. B. GRAVEL PIT

01/17/61

James I. Boyd

3 1
FOR STATE
HEALTH DEPT. (M)
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10617 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
10610											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North Brentwood						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North Brentwood					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4508 - 41st. Avenue						d. STREET ADDRESS 4508 - 41st. Avenue					
3. NAME OF DECEASED (Type or print) Georgianna						4. DATE OF DEATH September 27, 1961					
5. SEX Female						6. COLOR OR RACE Colored					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH Dec. 18, 1883					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10b. KIND OF BUSINESS OR INDUSTRY Own Home					
11. BIRTHPLACE (State or foreign country) Virginia						12. CITIZEN OF WHAT COUNTRY? U.S.A					
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. No					
17. INFORMANT Lorretta Stockett, same as # 2						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Carcinoma of the stomach (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED Sept. 27, 1961					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL						22b. DATE THEREOF 9.30.61					
22c. NAME OF CEMETERY OR CREMATORY SHARP STREET MUTUAL						22d. LOCATION (City, town, or country) (State) SANDY SPRING, MARYLAND					
23. FUNERAL DIRECTOR Robert L. McElwaine						24a. REC'D BY REGISTRAR SEP 29 '61					
ADDRESS 1820 9TH ST., N.W. WASHINGTON, D.C.						24b. REGISTRAR'S SIGNATURE C. H. S. H. H.					

10010

10010

(M)

Prince George's
 North Brentwood
 40 years
 Prince George's

4508 - 41st Avenue
 4508 - 41st Avenue

Georgiana
 Dec 18, 1903
 37
 September 23, 1901

Female Colored
 On Rose
 Virginia
 U.S.A.

Unknown
 Unknown

No
 No
 No

Identification
 Identification

Carcinoma of the stomach
 Carcinoma of the stomach

No
 No
 No

No
 No
 No

No
 No
 No

No
 No
 No

No
 No
 No

No
 No
 No

No
 No
 No

No
 No
 No

No
 No
 No

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10618

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film 8295 9/25/61 ink

10611

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Forestville

c. LENGTH OF STAY IN 1b

3 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Forestville Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if Institution residence before admission)

a. STATE

Maryland

b. COUNTY

Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

21 Forestville

d. STREET ADDRESS

Marlboro Pike NE

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

James

Burke

Story

4. DATE OF DEATH

Sept

Day

Year

1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

July 10, 1888

9. AGE (In years last birthday)

73

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Painter

10b. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

Yes

WWI

16. SOCIAL SECURITY NO.

579-40-4072

17. INFORMANT

Shirley M. Jones

Address 7512 Sherwood Ave, Upper Marlboro

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

Cerebrovascular accident

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

Cardiovascular renal disease

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour e.m.
p.m.

Month, Day, Year
19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

James I. Boyd

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

9/16/61

EXAMINER'S NAME (Type)

James I. Boyd

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

9/20/61

22c. NAME OF CEMETERY OR CREMATORY

Arl. Nat'l. Cemetery

22d. LOCATION (City, town, or country)

Arl. Va.

(State)

23. FUNERAL DIRECTOR

ADDRESS

W. W. Chambers Co. 5701 Cleveland Ave

24a. REC'D BY REGISTRAR

SEP 19 '61

24b. REGISTRAR'S SIGNATURE

Carlton S. Hines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

(M)

10013

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10013

[Faint, mostly illegible text and markings on a medical certificate form, including fields for patient information, medical history, and examination findings.]

[Vertical text on the right margin, likely a filing or tracking number, mostly illegible.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10619

CERTIFICATE OF DEATH

Reg. Dist. No. 10612

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY <u>WASHINGTON D.C.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHILLUM</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C.</u>		
c. LENGTH OF STAY IN 1b <u>4 yrs.</u>			d. STREET ADDRESS <u>4444-YUMA ST. N.W.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine A Sullivan</u>			4. DATE OF DEATH Month Day Year <u>9-8-1961</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-6-1875</u>		9. AGE (In years last birthday) <u>86</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>IRELAND.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>DANIEL P. O'CONNOR.</u>			14. MOTHER'S MAIDEN NAME <u>CATHERINE HEALY</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>MAURICE O'CONNOR - 4444-YUMA ST. N.W.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis with Myocardial</u> <u>420.0</u> DUE TO Infarction. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>3 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/26/1958</u> , 19____, to <u>9/8/1961</u> , 19____, that I last saw the deceased alive on <u>9/7/1961</u> , 19____, and that death occurred at <u>11:35 A.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Thomas F. Collins</u> M.D.			ADDRESS (Street, city or town, state) DATE SIGNED <u>322-H. St. N.E. 9-8-1961</u>		
PHYSICIAN'S NAME (Type) <u>Thomas F. Collins, M.D.</u>			<u>Washington 2, D.C.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9-11-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Naulon - 3831 GA. AVE. N.W.</u>			24a. REC'D BY REGISTRAR DATE <u>SEP 14 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DELIVER BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
10620 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10613													
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg d. STREET ADDRESS 4107 51st Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Charles			First		Middle		Last		4. DATE OF DEATH Month September Day 30 Year 1961				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 24, 1908		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fountain Manager				10b. KIND OF BUSINESS OR INDUSTRY Peoples Drug Stores				11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Szenas					14. MOTHER'S MAIDEN NAME Unknown								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) 1926 1926				16. SOCIAL SECURITY NO.		17. INFORMANT Charlotte Szenas, same as #2 Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hematoma 903.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of the skull DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury In Part I or Part II of item 18.) Fell in the street									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9/29/ 19 61 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Bladensburg		(County) P.G.		(State) Md		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd M.D.										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) James I. Boyd, M.D.										DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) 8200 Marlboro Pike, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 4, 1961		22c. NAME OF CEMETERY OR INTERMENTARY Arlington National				22d. LOCATION (City, town, or country) (State) Arlington Va					
23. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville Md.						24a. REC'D BY REGISTRAR OCT 4 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines					

10613

10630

(N)

2-31-72

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
10621

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10614

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Prince George's</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>MADISON MANOR</i>				d. STREET ADDRESS <i>P.O. Box 194</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Henry E. Thornberry</i>				4. DATE OF DEATH <i>Sept 9 1961</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 7, 1895</i>	9. AGE in years (last birthday) <i>66</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired car inspector</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Washington Term.</i>		11. BIRTHPLACE (State or foreign country) <i>Washington D C</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>
13. FATHER'S NAME <i>Edward E Thornberry</i>				14. MOTHER'S MAIDEN NAME <i>Amanda -</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Nellie C Thornberry Bowie, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arterial Hypertension</i> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <i>3 mo.</i> <i>5 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>8/30 1961</i> to <i>9/9 1961</i> , that (I) (we) last saw the deceased alive on <i>9/8 1961</i> , and that death occurred at <i>5:30 AM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Harold F. McCann</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>9/9/61</i>			
22c. PHYSICIAN'S NAME (Type) <i>HAROLD F. MCCANN</i>		22d. ADDRESS <i>3355 - 16th St. N.W. Wash. D.C.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sept 12, 1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Church of Ascension Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Bowie, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>				ADDRESS <i>Hyattsville, Md.</i>		25a. REC'D BY REGISTRAR <i>SEP 14 '61</i>	
				25b. REGISTRAR'S SIGNATURE <i>Wm. S. Thomas</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10622 CERTIFICATE OF DEATH 10615											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE District of Columbia b. COUNTY District of Columbia ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Glenn Dale						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington					
c. LENGTH OF STAY IN 1b 1 year, 28 das.						d. STREET ADDRESS 1225 L Street, N. W.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ida A. Thornton						4. DATE OF DEATH Sept. 17 1961					
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 16, 1871		9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (County & State, or foreign country) Jefferson County, Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harrison Rainwater						14. MOTHER'S MAIDEN NAME Elizabeth Lewis					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. none		17. INFORMANT Person		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis, 0021 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 1 yr., 1 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis; fracture of right humerus and right femur 8/61; open reduction, right femur fracture, 8/61											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/19/60 2:40 to 9/17/61 19....., that (I) (we) last saw the deceased alive on 9/17/61 19....., and that death occurred at A.M., from the causes and on the date stated above.											
22a. SIGNATURE Moe Weiss						22b. DATE SIGNED 9/17/61		22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.			
22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 21/61		23c. NAME OF CEMETERY OR CREMATORY CHESTNUT HILLS		23d. LOCATION (City, town or county) (State) CHESTNUT HILLS, TENNESSEE					
24. FUNERAL DIRECTOR'S SIGNATURE Hysong's Funeral Home				ADDRESS WASH. D.C. 1300-2nd St. N.W.		25a. REC'D BY REGISTRAR DATE SEP 19 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hous			

5539 I

1502

1994

1. *Leg. 1990 CD* (1990)

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

1
FOR STATE HEALTH DEPT. M

10623

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10616

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Oxon Hill		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 18271 Livingston Road		
3. NAME OF DECEASED (Type or print) LeRoy Vanderbeck			4. DATE OF DEATH Month September Day 27 Year 19 61		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH January 17, 1899		9. AGE (In years last birthday) 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Fred Vanderbeck		14. MOTHER'S MAIDEN NAME Alice Wright			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 490X		17. INFORMANT Dorothy L. Sprinkle Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia DUE TO (b) Lobar Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Sept. 27, 1961	
EXAMINER'S NAME (Type) James I. Boyd		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE HEREOF 9-29-61		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
23. FUNERAL DIRECTOR Summers Bros.		ADDRESS 1661 - Wood Hope Rd SE Wash DC		22d. LOCATION (City, town, or country) (State) Southland Md	
24e. REC'D BY REGISTRAR SEP 29 '61		24f. REGISTRAR'S SIGNATURE C. H. H. H.			

(M)

Prince George's General Hospital

1952

January 17, 1952

James I. Boya

Labster

James I. Boya

Labster

James I. Boya

Labster

James I. Boya

Labster

James I. Boya

Labster

James I. Boya

Labster

James I. Boya

Labster

James I. Boya

1
B
M
077
I
2
1
OP
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be received by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10624
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10617

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leonard Middle F. Last Vass		4. DATE OF DEATH Month September Day 3 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-10-1894
9. AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Issac Vass		14. MOTHER'S MAIDEN NAME ? Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Leonard E Vass		Address Berwyn Heights, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Coronary Arteriosclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured hip INTERVAL BETWEEN ONSET AND DEATH hours years			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 1 19 61 to Sept. 3 19 61 , that (I) (we) last saw the deceased alive on Sept. 3 19 61 and that death occurred at 7:05 P.M. M, from the causes and on the date stated above.			
22a. SIGNATURE Samuel S. Sugar		22b. DATE 9/4/61	
22c. PHYSICIAN'S NAME (Type) Dr. Samuel S. Sugar, M.D.		22d. ADDRESS 5801 Baltimore Ave., Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 6, 1961	
23c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		23d. LOCATION (City, town, or county) (State) Hyattsville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR SEP 8 '61	
ADDRESS Hyattsville Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Harris	

10017

CERTIFICATE OF DEATH

10024

THIS CERTIFICATE OF DEATH is hereby certified to be a true and correct copy of the original as the same appears from the records of the Registrar of Deaths for the City and County of Louisville, Kentucky, in the year 1901.

Witness my hand and the seal of the Registrar of Deaths for the City and County of Louisville, Kentucky, this 1st day of January, 1902.

Registrar of Deaths for the City and County of Louisville, Kentucky.

1902

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10625

10618

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY P. GEO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRANDYVINE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/BRANDYVINE	
c. LENGTH OF STAY IN 1b 32 YRS.		d. STREET ADDRESS RT 2 Box 257 A	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RT 2 Box 257 A		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) THEODORE FRANCISCUS WARFFENIUS		4. DATE OF DEATH SEPT. 5 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 28, 1889
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER	10b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED	11. BIRTHPLACE (County & State, or foreign country) DELFT, HOLLAND	12. CITIZEN OF WHAT COUNTRY? NETHERLANDS
---	---	--	--

13. FATHER'S NAME THEODORE F. WARFFENIUS	14. MOTHER'S MAIDEN NAME JOHANNA LANGE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	16. SOCIAL SECURITY NO. 217-03-2346
17. INFORMANT WIFE Address RT 2 Box 257 A	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 TERMINAL BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL EMBOLUS - INTERMITTENT VENTRICULAR ARRHYTHMIA DUE TO (c) ANTERIOSEPTAL-MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH 48 HRS.
---	--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). BENIGN PROSTATIC HYPERTROPHY WITH UREMIA.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---	--	--

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING TO CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) None	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None
20c. TIME OF INJURY Month, Day, Year None	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	20f. (City or town) (County) (State) None

21. I certify that (I) (the doctor) attended the deceased from **Sept 5, 1961** to **Sept 5, 1961** that (I) (we) last saw the deceased alive on **Sept 5, 1961** and that death occurred at **10 AM** from the causes and on the date stated above.

22a. SIGNATURE Arthur Shaver Jr.	M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9/5/61
22c. PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR.		22d. ADDRESS BRANCH AVE. - CLINTON, MD.	

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 9-8-61	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION (City, town or county) (State) Bladensburg md
---	------------------------------------	--	---

24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.	ADDRESS 1661 - Good Hope Rd SE WASH. DC 20002	25a. REC'D BY REGISTRAR SEP 7 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Hanna
--	---	---	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1000

RECEIVED

1000

M

I

1
M
C
07
I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10626						10619					
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brandywine d. STREET ADDRESS Rt. 2 Box 160 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Baby Boy Male Colored			4. DATE OF DEATH Month September Day 14 Year 1961			5. SEX Male			6. COLOR OR RACE Colored		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH 13 September 13, 1961			9. AGE (In years last birthday) 1 Months 1 Days 1 Hours 1 Min. 1			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prince George's Co., Md.		
11. BIRTHPLACE (County & State, or foreign country) U.S.A.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Joseph Herbert Swann			14. MOTHER'S MAIDEN NAME Thelma Mae Washington		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give number and date of service)			17. INFORMANT Address			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Atelutasis Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 762.5 DUE TO Atelutasis Prematurity INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
21. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			22. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			24. (City or town) (County) (State)		
25. I certify that (I) (this hospital) attended the deceased from 9/13 , 19 61 , to 9/14 , 19 61 , that (I) (we) last saw the deceased alive on 9/14 , 19 61 , and that death occurred at 1:10 M, from the causes and on the date stated above.											
26. SIGNATURE John Perkins M.D.			27. ATTENDING PHYS. <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			28. DATE SEP 25 '61			29. SIGNATURE Arthur S. Kraus		
30. BURIAL, CREMATION, REMOVAL (Specify) cremation			31. DATE THEREOF 9/21/61			32. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp			33. LOCATION (City, town or county) (State) Cheverly, Maryland		
34. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penny, Jr. Administrator			35. ADDRESS 2077171842			36. REC'D BY REGISTRAR SEP 25 '61			37. REGISTRAR'S SIGNATURE Arthur S. Kraus		

10013

10025

M

1

W. H. H. H.

4/14

4/13

4/14

X

John H. H.

... ..

...

...

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any copy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10627 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10620											
1. PLACE OF DEATH a. COUNTY <i>Pr Geo</i>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>D.C.</i> b. COUNTY <i>Washington</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Chesley</i>						c. LENGTH OF STAY IN 1b <i>Do A</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Pr Geo General</i>						d. STREET ADDRESS <i>67 Pst N.W.</i>					
3. NAME OF DECEASED (Type or print) First <i>McVay</i> Middle <i>Aloysius</i> Last <i>Washington</i>						4. DATE OF DEATH Month <i>9</i> - Day <i>15</i> Year <i>1961</i>					
5. SEX <i>M</i>		6. COLOR OR RACE <i>Colored</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept 30, 1919</i>		9. AGE (In years last birthday) <i>41</i> yrs.		10. IF UNDER 1 YEAR Months <i>11</i> Days <i>15</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i>				11. BIRTHPLACE (State or foreign country) <i>District of Columbia</i>			
12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>											
13. FATHER'S NAME <i>OWEN J. Washington</i>						14. MOTHER'S MAIDEN NAME <i>Lillie Washington</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>						16. SOCIAL SECURITY NO. <i></i>					
17. INFORMANT <i></i>						Address <i></i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Lacerations & Contusions</i> 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Fractured Skull - Swelling</i> DUE TO (c) <i>Multiple Wounds from bullet</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i></i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <i></i>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Subject hit by an automobile</i>					
20c. TIME OF INJURY Month, Day, Year <i>10 9/15 61</i> Hour a.m. <i></i> p.m. <i></i>						20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Alexander's Hardware</i>						20f. (City or town) <i>BLADENSBURG MD</i> (County) <i></i> (State) <i></i>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Dayton Watkins</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <i>DAYTON O WATKINS</i>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>						22b. DATE THEREOF <i>9.20.61</i>					
22c. NAME OF CEMETERY OR CREMATORY <i>MT. OLIVET CEMETERY</i>						22d. LOCATION (City, town, or country) <i>WASHINGTON, D.C.</i>					
23. FUNERAL DIRECTOR <i>Robert A. McQuire</i>						24a. REC'D BY REGISTRAR <i>SEP 19 '61</i>					
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>											

10050

10050

(M)

(I)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

10628

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10621

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital, Andrews AFB		d. STREET ADDRESS 18 McKay Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THELMA Middle RUTH Last WATSON		4. DATE OF DEATH Month Sept Day 17 Year 19 61	
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 March 1922
9. AGE (In years lost birthday) yrs. 39		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BX Manager		10b. KIND OF BUSINESS OR INDUSTRY Merchandising	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J. Edgar & Quicksall		14. MOTHER'S MAIDEN NAME Dora B. Lovely	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWII (Jan-Jun 42) 234-28-4075	
17. INFORMANT Husband		Address 18 McKay Road, Brandywine, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of cervix, metastatic to peritoneum DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 3 years 1 month	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 15 Aug 61 to 17 Sep 1961 , that (I) (we) last saw the deceased alive on 17 Sep 19 61 , and that death occurred at 0640 M, from the causes and on the date stated above.			
22a. SIGNATURE Paul F. Griner		22b. DATE SIGNED 17 Sep 61	
22c. PHYSICIAN'S NAME (Type) PAUL F. GRINER, CAPT, USAF MC		22d. ADDRESS USAF Hospital, Andrews AFB, Wash 25, DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-20-61	
23c. NAME OF CEMETERY OR CREMATORY Field BRANCH		23d. LOCATION (City, town, or county) (State) TAULBEE, KENTUCKY	
24. FUNERAL DIRECTOR'S SIGNATURE The HUNT FUNERAL HOME, WALDORF, MD.		25a. REC'D BY REGISTRAR DATE SEP 20 '61	
25b. REGISTRAR'S SIGNATURE 17-11-0000			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
10622
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u> c. LENGTH OF STAY IN 1b <u>13 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SOUTHERN MARYLAND HOSP. CENTER</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence prior to admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>P. Geo.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u> d. STREET ADDRESS <u>RT 3 Box 579</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MINNIE C WAYMAN</u>		4. DATE OF DEATH <u>SEPT. 30 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 31-1876</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PHILLIP BOWEN</u>		14. MOTHER'S MAIDEN NAME <u>EMMA ROADE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. GEORGETH HORNSTON</u> Address <u>RT 3 Box 579 CLINTON MD</u> <u>NIECE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTERNAL HEMORRAGE (G.I. TRACT)</u> 204.1 DUE TO (b) <u>MONOCYTOID LEUKEMIA - ALEUKEMIC PHASE 13 DAYS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>NONE</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGESTIVE HEART FAILURE, COMPENSATED</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NONE</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year <u>NONE</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <u>NONE</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>NONE</u>		20f. (City or town) <u>NONE</u> (County) <u>NONE</u> (State) <u>NONE</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>9/17</u> 19 <u>61</u> to <u>PRESENT</u> , that (I) (we) last saw the deceased alive on <u>SEPT 29</u> 19 <u>61</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur Shaver Jr</u> M.D.		22b. DATE SIGNED <u>9/30/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR MD</u>		22d. ADDRESS <u>BRANCH AVE - CLINTON, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/3/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MARSHALL CEMETERY</u>		23d. LOCATION (City, town or county) <u>MARSHALL VA</u> (State) <u>VA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS</u> ADDRESS <u>C-517-1155 5150 W. W. CHAMBERS</u>		25a. REC'D BY REGISTRAR <u>OCT 3 '61</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	

10682

10682

(M)

(7)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10623

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt d. STREET ADDRESS 32-A Crescent Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b 2 days				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Nohre M. Wehn				4. DATE OF DEATH Month Day Year September 19 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-21-81	
9. AGE (In years last birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier - (Retired)		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David C. Holliday				14. MOTHER'S MAIDEN NAME Emma H. Benton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 579-03-1273			
17. INFORMANT Richard G. Wehn				32-A Crescent Road Greenbelt, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 9/17 , 19 61 , to 9/19 , 19 61 , that (I) (we) last saw the deceased alive on 9/17 , 19 61 , and that death occurred 4:20 P.M. from the causes and on the date stated above. 22a. SIGNATURE C. Louis Menzel M.D. 22c. PHYSICIAN'S NAME (Type) C. LOUIS MENDEL, M.D. 22b. DATE SIGNED 9/19/61 22d. ADDRESS 4506 COLLEGE AVE COLLEGE PARK Md. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 9-22-61 23c. NAME OF CEMETERY OR CREMATORY Glenwood CEM 23d. LOCATION (City, town or county) (State) Washington, D.C1 24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers ADDRESS Riverdale, Md. 25a. REC'D BY REGISTRAR SEP 22 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

VR A15 (4)
15M 9/60

M

I

10833

10833

James George's

University

2 days

University

James George's General Hospital

12-1-1900

James

James

James

11-1-1901

11-1-1901

Cashier - (Retired) Capt. Stone

Washington, D. C.

11-1-1901

David O. Holliday

James H. Benton

32-A, Greenport Road

870-03-1273 Richard A. Venn Greenport, Md.

James H. Benton

James H. Benton

James H. Benton

James H. Benton

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10631 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Beltsville					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital						d. STREET ADDRESS 12106 Wheatley Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alice			First Alphansane Middle Wheatley Last			4. DATE OF DEATH September 22			Day 19 Year 61		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 1, 1918		9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) New York			12. CITIZEN OF WHAT COUNTRY? U.S. A		
13. FATHER'S NAME Henry Burnette						14. MOTHER'S MAIDEN NAME ELIZABETH TOOMEL					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 224-48-6301		17. INFORMANT Address Edward Earl Wheatley, same as # 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 493X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FAT Infiltration, Liver											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 9/22/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9-25-61		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or country) (State) Bladensburg, Md.			
23. FUNERAL DIRECTOR ADDRESS W. W. Chambers Co. Riverdale, Md.						24a. REC'D BY REGISTRAR DATE SEP 26 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

De 14 van 15

• • •

noch viel

6405 MC

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

VR A15 (4)
15M 9/59

10632

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10625

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D. O. A.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Edward Last Williams		4. DATE OF DEATH Month Sept. Day 23, Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1906
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 5 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Candy Co.	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Williams		14. MOTHER'S MAIDEN NAME Marie Vensade	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Helen E. Williams Same as # 2 Wife		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.00 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-17 to 9-23 19 61 , that (I) (we) last saw the deceased alive on 9-8 19 61 , and that death occurred at M from the causes and on the date stated above.			
22a. SIGNATURE A. Reitz		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/26/61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR DATE SEP 27 '61	
ADDRESS Hyattsville, Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

17

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

10633
10626

10633 Item 13 Film G297 10/2/61 mb

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
a. COUNTY				a. STATE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
Prince Georges				Maryland			
Cheverly				Bowie			
Prince Georges General Hospital				6th Street			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Middle Last				Month Day Year			
Lewis				Sept. 27 19 61			
5. SEX				6. COLOR OR RACE			
Male				Black			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				17 Jan 1917			
9. AGE (In years last birthday)				44 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
Short order Cook							
11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
So. HAMPTON, VA.				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Nathaniel Woodard				EMMA SCOTT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.			
YES W.W.# 2				517-12-6508			
17. INFORMANT				Address 49 6TH ST			
Mrs. FRANCES WOODWARD ROWIE, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Duodenal ulcer with hemorrhage				2 months			
541.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO			
				(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED?			
Uremia				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED			
Hour a.m. p.m. 19				While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9/17, 1961, to 9/27, 1961, that (I) (we) last saw the deceased alive on 9/27, 1961, and that death occurred at 6:05 PM, from the causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED			
James R. Goodson, M.D.				9/27/61			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
James R. Goodson, M.D.				1746 K St. N.W. Washington 6 D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF			
BURIAL				10.1.61			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
GOLFFIELD CEMETERY				IVOR, VIRGINIA			
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR			
Robert F. McGuire				25b. REGISTRAR'S SIGNATURE			
1820 9TH ST., N.W.				DATE SEP 29 '61			
WASHINGTON, D.C.				Arthur S. Frank			

M

1

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

10033

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If entry is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10634 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution, give address of admission) a. STATE District of Columbia b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 2829 Gainesville Street S.E.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Camp Springs						c. LENGTH OF STAY IN 1b 1 week					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7263 Brinkley Road						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mary Elizabeth Young						4. DATE OF DEATH September 21 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 15, 1909		9. AGE (In years birth day) 52 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) District of Columbia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Harry Styron						14. MOTHER'S MAIDEN NAME Mary Hart					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address William P. Young, same as # 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastasis to the liver DUE TO (b) Carcinoma of the right breast. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/22/61			
EXAMINER'S NAME (Type)		James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)					
Burial		SEP. 25-61		Arlington Natl.		Arlington Va					
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Ammons Bros.		1661 - C St N.W. WASH DC		DATE SEP 25 '61		Arthur L. House					

10032

10032

M

I

James I. Boyd
Harry Byron
Rosalie
William E. Young, wife
May 19, 1900
District of Columbia
U.S.A.
Washington
District of Columbia
May 19, 1900
District of Columbia
U.S.A.

Not at all to the right
of the right hand

9/2/01

James I. Boyd

VS. A15ME
SM 9/60

DATE SEP 7 '61

September 6, 1961

DATE SEP 7 '61

UNITED STATES
NAVY

(V)

(1)

RECEIVED

10035

Medical Department

Quartermaster

U.S.A.

U.S.A.

Medical Department, General Hospital, 1117 22nd Street, S.W., Washington, D.C.

William Young

Wife of William Young, 1117 22nd Street, S.W., Washington, D.C.

-75

Office

Maintainance of the Medical Department, General Hospital, 1117 22nd Street, S.W., Washington, D.C.

U.S.A.

Robert Bruce Young, 1117 22nd Street, S.W., Washington, D.C.

W. I. Young

Robert Bruce Young, 1117 22nd Street, S.W., Washington, D.C.

Route 1, 1117 22nd Street, S.W., Washington, D.C.

Quartermaster, 1117 22nd Street, S.W., Washington, D.C.

James I. Boyd

U.S.A.

TO ALL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10636

CERTIFICATE OF DEATH

Item 23b, Film G295 9/25/61 iwk

10629

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: residence, before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 74 Beltsville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 4514 Sellman Road	
3. NAME OF DECEASED (Type or print) Robert H. Zieport		4. DATE OF DEATH Sept. 18, 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 13, 1889
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Zieport		14. MOTHER'S MAIDEN NAME Margaret Mann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 577-10-1191	
17. INFORMANT Elsie G. Zieport Same as # 2		Address Wife	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO 4200 Conditions, if any, which gave rise to immediate cause (b) CORONARY THROMBOSIS (c) DUE TO ANTHEROSCLEROTIC HEART DISEASE cause last.		INTERVAL BETWEEN ONSET AND DEATH 12 hrs 24 hrs 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/14 to 9/18, 1961, that (I) (we) last saw the deceased alive on 9/18, 1961, and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Norman Donat Comen		ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) NORMAN DONAT COMEN		22b. DATE SIGNED 9/18/61	
22d. ADDRESS 3503 Penry St MT RAINIER MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 21, 1961	
23c. NAME OF CEMETERY OR CREMATORY St. John's Church		23d. LOCATION (City, town or county) Beltsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland	
25a. REC'D BY REGISTRAR SEP 20 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kneiss	

ES&H

2890

M

12-1-1941

• • •

242

WRIGHT, J. H. 1917. The life history of the

1984

2008-09-17

१८५२ ई. दिनांक २७ ४ ५३३२५१५०५

10 85/2 12 8-3/4

11-27-11

1-31-158

Handwritten signature: *Wm. L. G. ...*

[Faint handwritten notes at the bottom of the page]